



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 4 6 4  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA ACKERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 10 80</b>		2b. HOUR <b>6:30 P.M.</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 1, 1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CCNCC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2305 Washington Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leon Honikman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hannah Goodman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-48-7612D</b>		17. INFORMANT ADDRESS <b>Morris Ackerman; 2307 Ashboro Dr, Ch.Ch., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease; Intracerebral Hemorrhage</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>4 years</b> <b>10 yrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 76</b> to <b>7/10 80</b> , that (I) (we) last saw the deceased alive on <b>7/21 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel DeRoss M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/10/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL DEROSS</b>				22e. ADDRESS <b>4501-Camm Ave N.W. 20008</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-11-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ezras Israel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Capitol Heights, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels;</b>				ADDRESS <b>1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1980</b>			
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 6 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dwight J. ADAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 24 1980</b>		2b. HOUR <b>1030A M</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 11 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Adams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie Price</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>330 18 7101</b>		17. INFORMANT ADDRESS <b>Mrs. Bernadette Adams See item 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Metastatic bronchogenic carcinoma</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 23 1980</b> to <b>July 24 1980</b> , that I (we) lost saw the deceased alive on <b>July 24 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gary G. Sladek</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>July 25, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary G. Sladek, M.D.</b>		22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-29-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Va.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robt. A. Pumphrey Funeral Home, Rockville, Md.</b>		25a. DISTRIBUTED BY REGISTRAR <b>AUG 6 1980</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED  
UNITED STATES DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

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[illegible signature]

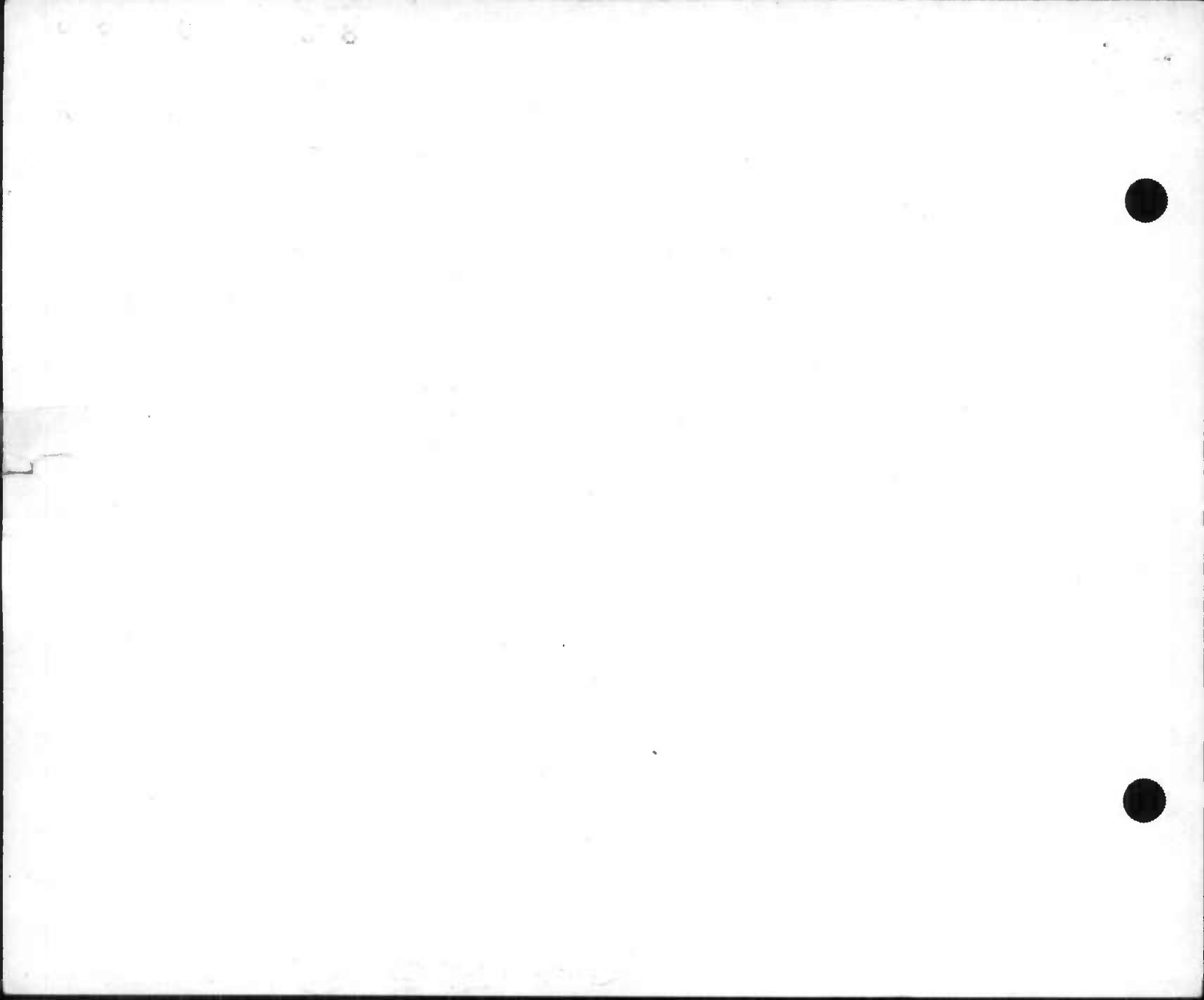


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 8 4 6 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie L. Adams				2a. DATE OF DEATH MONTH DAY YEAR 7 14 80 2b. HOUR 12 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 8 1889		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor Care Nursing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Montgomery			
13c. CITY OR TOWN Sil. Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Julius Henry Stanowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Rex			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT (Niece) ADDRESS Mrs. Billie S. Gillis- (same as 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> 492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital attended the deceased from <u>June 19 80</u> to <u>July 14 80</u> , that (I) <u>yes</u> last saw the deceased alive on <u>July 14 19 80</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>would</u> (did not) view the body after death.							
22b. SIGNATURE <u>Robert Kramer MD</u>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>7/14/80</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Kramer, MD				22f. ADDRESS 8630 Fenton Street, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-16-1980		23c. NAME OF CEMETERY OR CREMATORY Miami Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Miami Dade Florida	
24. FUNERAL DIRECTOR Wagner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR JUL 16 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Helen I. Addis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 28, 80</b>		2b. HOUR <b>7:45 P</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 29 1883</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96 YRS</b>		7. UNDER 1 YEAR MONTHS DAYS <b>96</b>		8. UNDER 24 HRS HOURS MIN. <b>45</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pt. Carmel, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sec., then housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5407 York Lane</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Roy</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Wright</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>577-84-5570</b>			17. INFORMANT (daughter) <b>Alice Washer</b>			ADDRESS <b>5407 York Lane, Bethesda, Md. 20014</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART'S YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>SEMI LIT 3</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 P.M. 7/29/80</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6116 Robinwood, Bethesda, Md.</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/31/80</b> to <b>July 28, 80</b> , that (I) (we) last saw the deceased alive on <b>7/31/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>THOS G. WARD, M.D.</b>						22c. DATE SIGNED <b>7/29/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOS G. WARD</b>						22e. ADDRESS <b>6116 Robinwood, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/31/80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince Geo. Md.</b>		

24. FUNERAL DIRECTOR  
**Rosebell Sandison 316 E. Diamond Avenue, Gaithersburg, Md. 20760**25a. DATE REC'D. BY REGISTRAR  
**AUG 04 1980**25b. REGISTRAR'S SIGNATURE  
**Robert J. [Signature]**

1018103

Handwritten notes and scribbles at the top of the page, including the number 1018103.

Handwritten notes and scribbles covering the bottom half of the page, including the number 1018103.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8018468	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Ronald Lee Alder</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 31 1980</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 8, 1957</b> 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>22</b> 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.										2b. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 31 1980</b> 2d. HOUR <b>4:06</b> P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, Md.</b>											
10. CITY OR TOWN OF DEATH <b>Bethesda</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>725 Briggs Chaney Road</b>											
14. FATHER'S NAME <b>William Raymond Alder</b> 15. MOTHER'S MAIDEN NAME <b>Barbara Carleen Ray</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>219-68-3840</b> 17. INFORMANT ADDRESS <b>William Alder Los Angeles Calif.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9554</b> IMMEDIATE CAUSE (a) <b>Shotgun Wound of Abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2:30 P.M. 7 31 1980</b> 21b. TIME OF INJURY HOUR XX. MONTH DAY YEAR <b>Subject shot self</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b> 21f. LOCATION CITY OR TOWN COUNTY STATE <b>22305 Georgia Ave., Brookville, Montgomery, Md.</b>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D. TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>8/1/80</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b> ADDRESS <b>111 Penn Street</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>Aug. 4, 1980</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Colesville</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colesville Mont. Md.</b>											
24. FUNERAL DIRECTOR <b>Francis H. Barber Laytonville, Md. 20760</b> 25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Rickie McCreedy</b>											

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF OF BUREAU  
WASHINGTON, D. C.

REPORT OF THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

THE CHIEF OF BUREAU  
FOR THE YEAR 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 4 6 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ERIK XXXX ANDERSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7-11-80</b>				2b. HOUR <b>5:00 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 29 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sweden</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>15 EAST FRANKLIN AVENUE</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN ANDERSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNA ERIKSSON</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16a. SOCIAL SECURITY NO. <b>578-03-0334</b>				17. INFORMANT <b>THELMA GEORGE</b>				ADDRESS <b>4875 35TH ROAD N. ARLINGTON, VIRGINIA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septic Shock</b> <b>2001</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Small bowel perforation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lymphoma of Small bowel-lymphocytic</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/10 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/10 19 80</b> to <b>7/11 19 80</b> that (I) (we) last saw the deceased alive on <b>7/11 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Herbert S. B. Baraf</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/10/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HERBERT S. B. BARAF</b>				22e. ADDRESS <b>8750 GEO. AVENUE, SILVER SPRING, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7/15/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D. C.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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WYLAND MONTGOMERY SILVER SPRING  
SILVER SPRING HOLY CROSS HOSPITAL  
CARPENTRY  
MONTGOMERY  
15 EAST FRANKLIN AVENUE

JOHN  
578-02-0321 THELMA GEORGE  
DAUGHTER  
BIRMINGHAM  
4175 15TH ROAD  
N. ARLINGTON, VIRGINIA

WYLAND MONTGOMERY SILVER SPRING  
WYLAND MONTGOMERY SILVER SPRING

500 101 SILVER SPRING, MD. 20904  
JUL 1 1960  
T. C. MONTGOMERY



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 7 0

1 - FOR  
STATE  
REGISTRAR

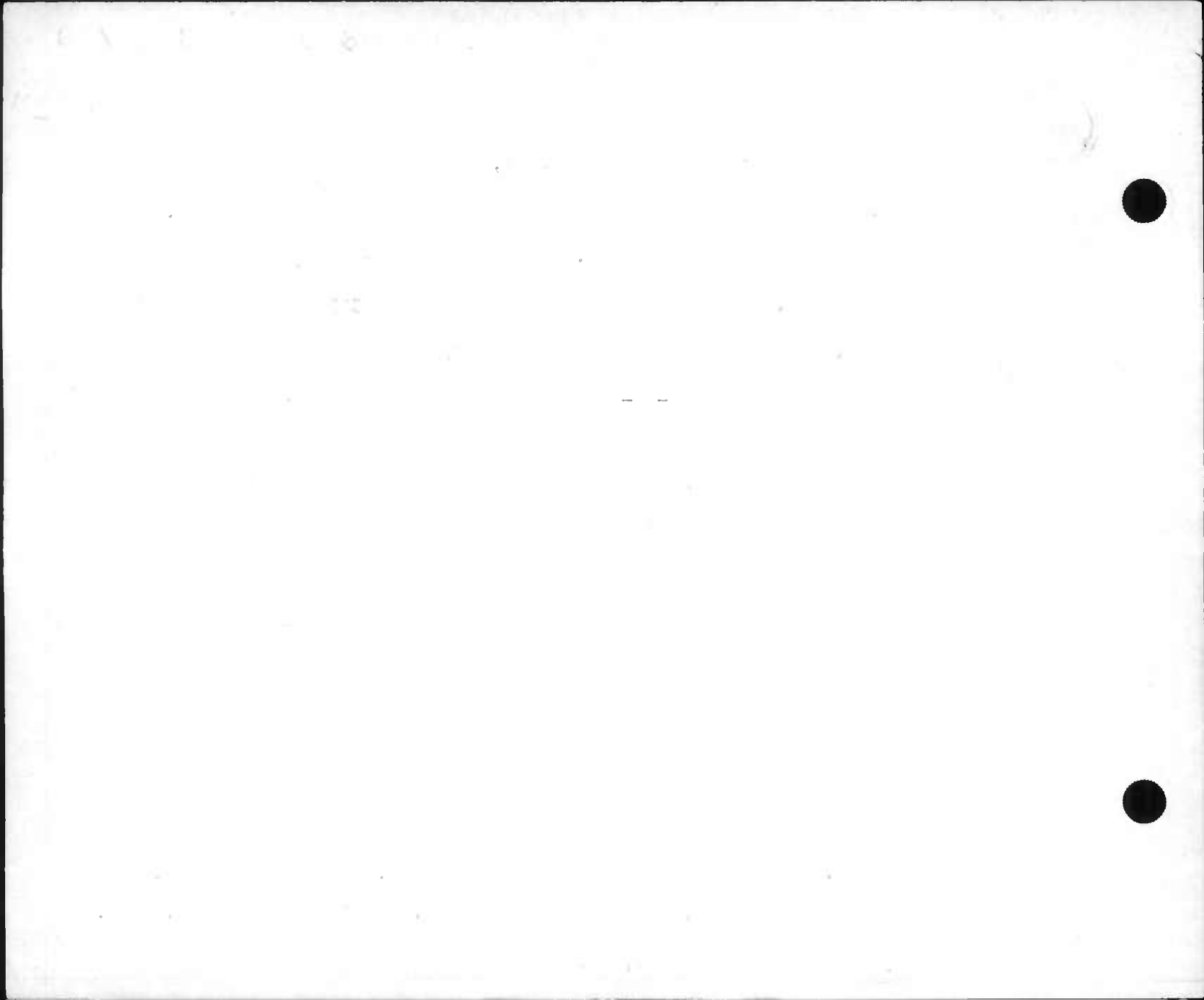
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN Thomas ANDREWS			2a. DATE OF DEATH MONTH DAY YEAR JULY 21 1980		2b. HOUR 12:55 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paint contractor		12b. KIND OF BUSINESS OR INDUSTRY Painting	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont.	13c. CITY OR TOWN Germantown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 19233 Frederick Road	
14. FATHER'S NAME FIRST MIDDLE LAST George M. Andrews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Emma Hawkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-5375		17. INFORMANT ADDRESS Ruth Andrews Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>7/13/80</u> 19 to <u>7/20/80</u> 19, that (b) (we) last saw the deceased alive on <u>7/20/80</u> 19, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) not view the body after death.						
22b. SIGNATURE <u>Pasqual Perrino</u> MD 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Pasqual V. Perrino				22d. ADDRESS Deer Park Dr. Gaithersburg, Md. 20760		22e. DATE SIGNED July 21, 1980
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 23, 1980	23c. NAME OF CEMETERY OR CREMATORY Clarksburg Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Clarksburg Mont. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20760			25a. DATE REC'D. BY REGISTRAR JUL 23 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8018471

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vasil Angeli</b>		July 2, 1980		7:44 P.M.	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 2 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>	7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ship's Captain</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>British Embassy</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Angeli</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marina Dalaportas</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>no</b>		16b. SOCIAL SECURITY NO. <b>578-76-5544</b>		17. INFORMANT ADDRESS <b>Iphigenia Angeli (same as 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>410-</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>years.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8 1950</b> to <b>July 2 1980</b> , that (I) (we) last saw the deceased alive on <b>May 20 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. <input checked="" type="checkbox"/>					
22b. SIGNATURE <b>Harris Kenner</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/3/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harris Kenner, M.D.</b>		22e. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION CITY OR TOWN <b>Silver Spring, Maryland</b>		23e. COUNTY <b>Montgomery</b>		23f. STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1 2 3 4 5 6 7 8 9 10 11 12

7:00

Jan. 2, 1907

Jan. 2, 1907

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville (same as 1907)

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

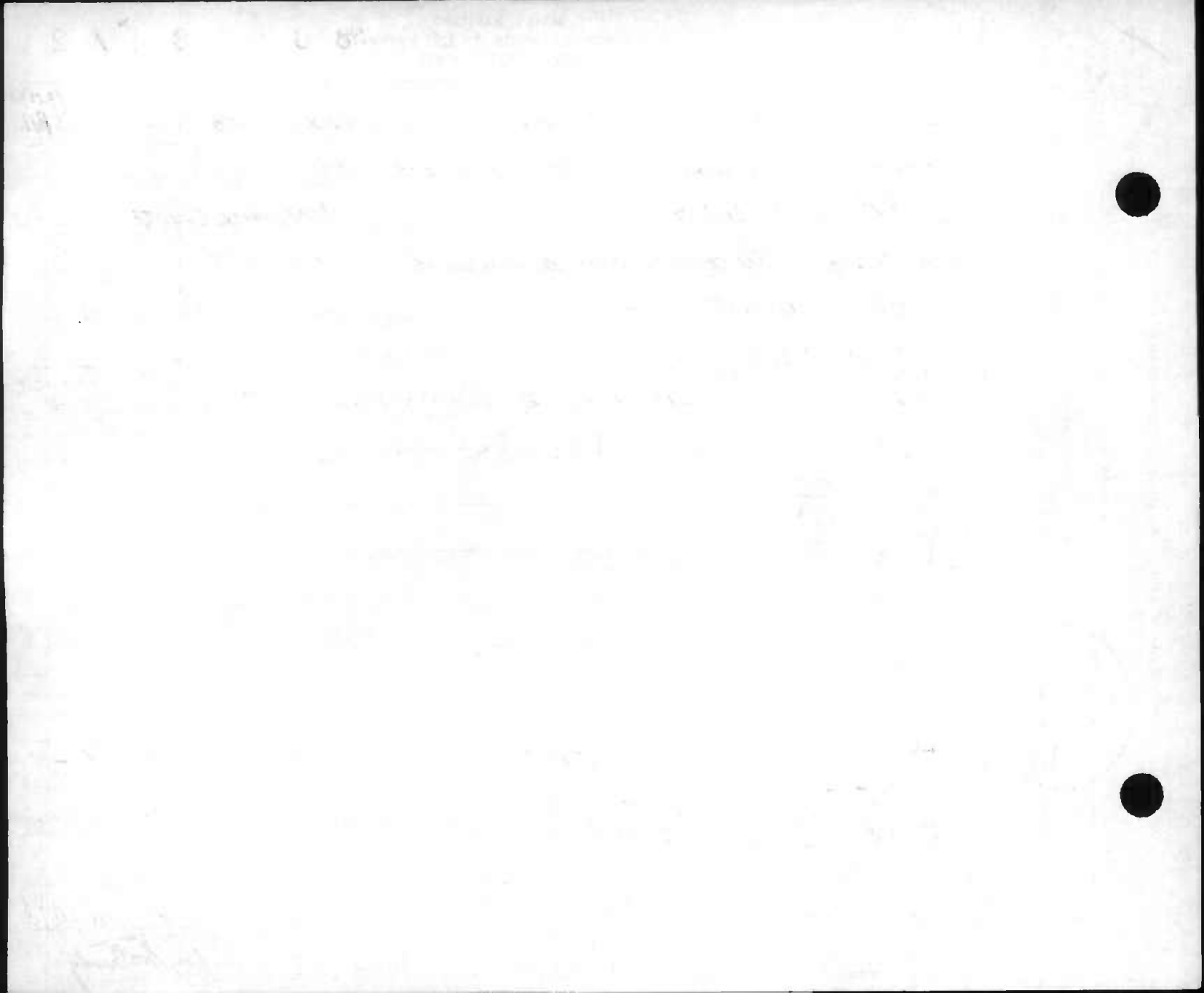
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 7 2

1 - FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ellen L. Bacon</i>		2a DATE OF DEATH MONTH DAY YEAR <i>July 18 1980</i>	
3 SEX <i>Female</i>	4 RACE <i>Black</i>	2b HOUR (P.M.) <i>11:15 AM</i>	
5 DATE OF BIRTH MONTH DAY YEAR <i>January 3, 1895</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 2 YEARS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>	MD.		
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>The Colonial Villa Nursing Home</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>
12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <i>Md.</i>	13b COUNTY <i>HOWARD</i>	13c CITY OR TOWN <i>DAYTON</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <i>HENRY LYLES</i>	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Thomas</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b SOCIAL SECURITY NO. <i>218-01-79910</i>	17 INFORMANT ADDRESS <i>2606 Chelsea Terrace Balt. Md. 21216</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a Verify that (I) (this hospital) attended the deceased from <i>2/28</i> , 19 <i>80</i> , to <i>7/10</i> , 19 <i>80</i> , that I (we) last saw the deceased alive on <i>7/10</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <i>Marion Chung MD</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <i>7-19-80</i>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARION CHUNG MD</i>	22e ADDRESS <i>Silver Spring MD</i>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b DATE <i>7-24-80</i>	23c NAME OF CEMETERY OR CREMATORY <i>Western Star Cem</i>	23d LOCATION CITY OR TOWN COUNTY STATE <i>CATONSVILLE, HOWARD MD.</i>
24 FUNERAL DIRECTOR NAME <i>George R. Snowden</i>	ADDRESS <i>246 N. Wash. Rockville, Md.</i>	25a DATE REC'D. BY REGISTRAR <i>JUL 25 1980</i>	25b REGISTRAR'S SIGNATURE <i>Dorothy McBrady</i>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 0 1 8 4 7 3		
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JANICE MARIE BANCROFT</b>										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 1 1980</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 7 '80</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN <b>24</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 1 1980</b>		2b. HOUR <b>8:10</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Olney, Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>0 Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Poolesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>14804 Sugarland Rd.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>David L. Bancroft</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Peggy Sue Hungerford</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>David L. Bancroft 14804 Sugarland Rd. Poolesville, Md. 20837</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>7980</b> IMMEDIATE CAUSE (a) <b>Sudden infant death syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Margaret A. Korall</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGN <b>7-2-80</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korall, M.D.</b>				ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 3, '80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boysds Presby. Ch. Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boysds Montgomery Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F. H.</b>				ADDRESS <b>316 E. Daimond Ave., Gaithersburg, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Emily Barry			2a. DATE OF DEATH MONTH DAY YEAR July 23, 1980		2b. HOUR 5:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 26, 1919		
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec'y.		
12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE West Virginia						
13b. COUNTY Harrison		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 215 Reno Street						
14. FATHER'S NAME FIRST MIDDLE LAST Albert R. Shaw			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Sinclair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-26-9055		17. INFORMANT ADDRESS C. Robert Barry, husband, same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphomatous meningitis DUE TO, OR AS A CONSEQUENCE OF (b) Progressive diffuse histiocytic lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) S/P Abdominoperineal resection with diverting colostomy.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from 17 July 1980 to 23 July 1980, that (X) (we) last saw the deceased alive on 23 July 1980, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)						
22b. SIGNATURE Gregory A. Curt, M.D. DEGREE				22c. DATE SIGNED July 24, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory A. Curt, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Bridgeport Cen. Bridgeport, W. Va.		
23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Homes, P.A.		25a. DATE REC'D. BY REGISTRAR JUL 29 1980		25b. REGISTRAR'S SIGNATURE Gregory A. Curt		

TO HOSPITALS, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George Grigorovich-BARSKY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 2 80</b>			2b. HOUR <b>1:45</b> M				
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 13 94</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kiev, Russia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>				
10 CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b>			13b COUNTY <b>Pr. Georges</b>		13c CITY OR TOWN <b>Lanhan</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e STREET ADDRESS <b>7815 Cross Street</b>										
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sergie Grigorovich-Barsky</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Olga Unk.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>225-50-8492</b>			17 INFORMANT <b>Marina Grigorovich-Barsky</b>			ADDRESS <b>same as (13)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO-SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>SEMI-CONSCIOUS</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) (the hospital attended the deceased from <b>July 2 80</b> to <b>July 2 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (all (wounded) (did not) view the body after death.										
22b. SIGNATURE <b>Mos G. Ward</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/2/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mos G. Ward</b>						22e. ADDRESS <b>6116 Robinwood, Bethesda, Md 20814</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 3, 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <b>DeVol Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
ADDRESS <b>2222 Wisconsin Ave. N.W.</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 7 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JULIA MARGARET BASSETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 16, 1980</b>			2b. HOUR <b>6:00 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 2, 1888</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>92</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>FAIRLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRLAND NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSING AID</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. CITY OR TOWN <b>BURTONSVILLE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3400 OAKHURST DRIVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH BRACKETT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLY ANN WILSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>303-28-4519</b>		17. INFORMANT ADDRESS <b>L. HAYNES BOATRIGHT (SAME AS #13 ABOVE)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC FAILURE</b> 3 days DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> YEARS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>STERILITY</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUN 8 1980</b> to <b>7/16 80</b> , that (I) (we) last saw the deceased alive on <b>7/15 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>THOS G. WARD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/16/80</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOS G. WARD</b>						22e. ADDRESS <b>6116 ROBINWOOD, BETHESDA, MD 20034</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JULY 18, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BURTONSVILLE MONTG. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>John H. Walters</b> ADDRESS <b>254 Carroll St. NW</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

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JANUARY 2, 1882

P.S.

MONTICEMERY

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U.S.A

KENTUCKY

WESLEYAN AID

FAIRLAND WORKING HOME

FAIRLAND

AND CARROLLTON DRIVE

WESTMINSTER

SALLY ANN WILSON

THURSDAY

JOSEPH

(SOME AS FID  
BECVE)

20-25-210 LINDSEY BOSTWICK

MO

TRINITY  
JAN 18 1882 UNION CHURCH  
BIRMINGHAM, ALA  
M.D.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 4 7 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR	
Obie						Bates		7		27		19		80		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	8 1 36		45						7		27		19		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Massachusetts		United States		WIDOWED		DIVORCED		Montgomery County,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		8521 Glenview Road		messenger		Office supply											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
D.C.		Washington		YES		NO		2642 Birney St. S.E. #302									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Unknown		Lula Bates															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
unknown		023 30 6522		Sylvia LaMar		2642 Birney St. S.E. 302											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		Cirrrosis of Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
5715		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		Virginia L. Dolan		TITLE (SPECIFY)		Assistant		MEDICAL EXAMINER		DATE SIGNED		7/28/80					
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		8 1 80		Harmony		Landover Maryland											
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Leroy Hodges		JUL 29 1980		Dorothy McCready													

11148108

UNITED STATES DEPARTMENT OF JUSTICE



OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRIEDA BAUM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-6-80</b>		2b. HOUR <b>11<sup>20</sup> PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 12, 1894</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Latvia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Latvia</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>9805 Hedin Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Smerin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hannah Horowitz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-78-1210</b>	17. INFORMANT <b>Samuel Baum</b>		ADDRESS <b>Same as No. 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>URINARY INFECTION, PNEUMONITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>SEVERE SENILE DEMENTIA</b>					
19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/27/77</b> , 19___, to <b>7/6/80</b> , 19___, that (I) (we) lost saw the deceased alive on <b>7/6/80</b> , 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D.D. Patel</b>		DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>7/7/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.D. PATEL</b>
22e. ADDRESS <b>6121 MONTROSE RD ROCKVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>7/8/1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elmont, Long Island, New York</b>		
24. FUNERAL DIRECTOR NAME <b>Donald M. Stein</b>		24b. ADDRESS <b>232 Carroll Street, N. W. Washington, D. C.</b>		25. DATE REC'D. BY REGISTRAR <b>JUL 9 1980</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>JEANNETTE</b>			FIRST MIDDLE LAST <b>BECKMAN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 17, 1980</b>			2b HOUR <b>12:10<sup>A</sup> M.</b>		
3 SEX <b>FEMALE</b>			4 RACE <b>White</b>			5 DATE OF BIRTH MONTH DAY YEAR <b>June 7, 1881</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>99</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Netherlands</b>			7b CITIZEN OF WHAT COUNTRY? <b>US</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a STATE <b>D.C.</b>			13b COUNTY <b>None</b>			13c CITY OR TOWN <b>Washington</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Karel W. den Hollander</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adriana van der Sluis</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>577-22-1450</b>		
17 INFORMANT <b>Miss Elizabeth Beekman Same as Item # 13</b>			18 ADDRESS <b>3636 --16 st N.W.</b>			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		
19c CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5319</b> IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Gastric Ulcer Osteoarthritis</b>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			22a I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 48</b> to <b>JULY 16 19 80</b> , that (we) last saw the deceased alive on <b>JUNE 23 19 80</b> , and that (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b SIGNATURE <b>Theodore J. Abenethy</b>		
22c DATE SIGNED <b>7-17-80</b>			22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Theodore J. Abenethy</b>			22e ADDRESS <b>916-19<sup>th</sup> St. N.W. D.C. 20006</b>			22f DATE REG'D BY REGISTRAR <b>JUL 21 1980</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>7/18/80</b>			23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>		
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME ADDRESS <b>1530 Wisc. Ave. N.W. Wash., D.C. 20016</b>						25a DATE REG'D BY REGISTRAR <b>JUL 21 1980</b>			25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

Cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 8 0

1- FOR  
STATE  
REGISTRAR

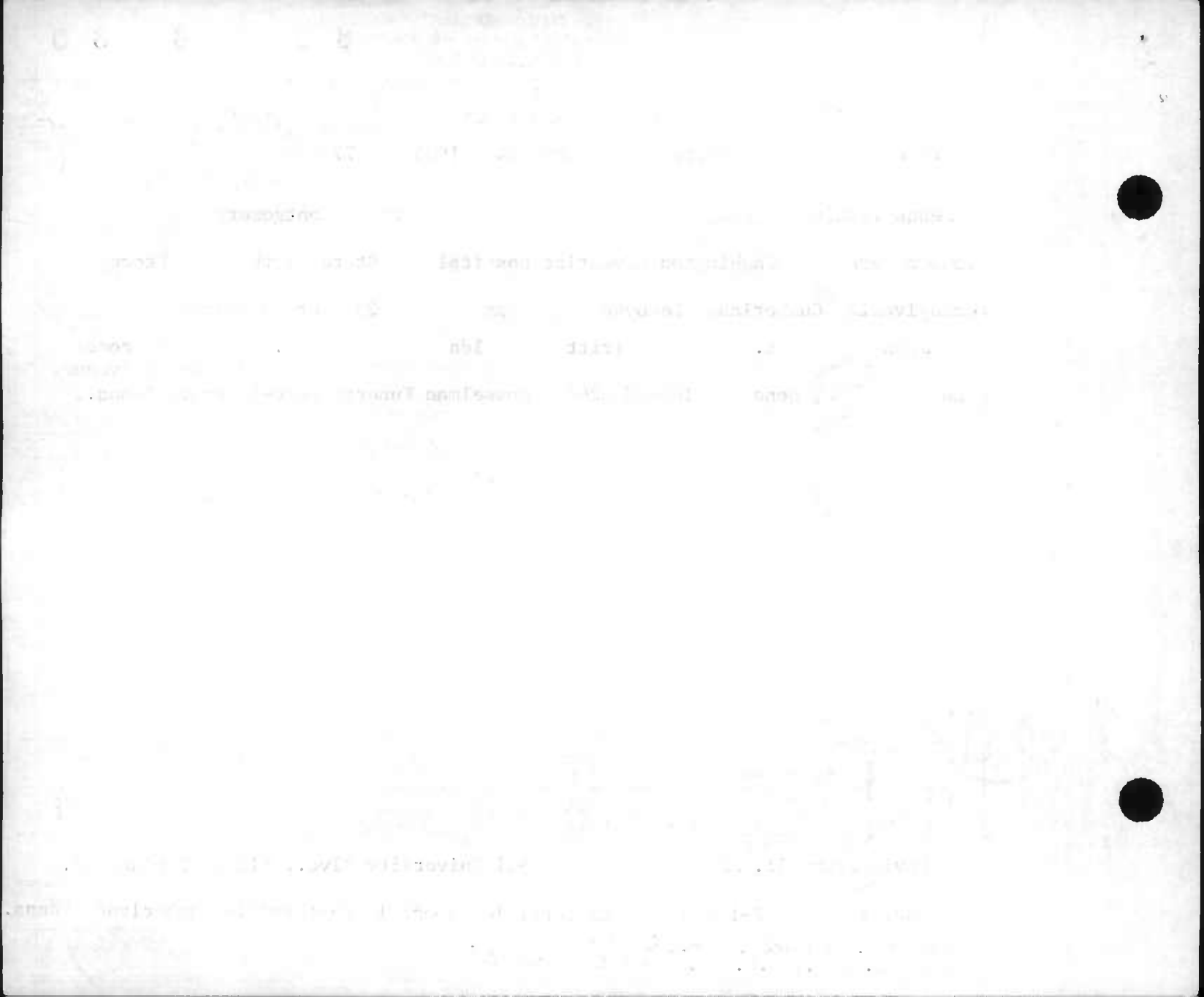
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Caroline Ida Beers</b>			2a. DATE OF DEATH <b>July 15, 1980</b>			2b. HOUR <b>11<sup>10</sup> A.M.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 24, 1903</b>		6. AGE (IN YEARS) <b>77</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Store Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		
13a. STATE <b>Pennsylvania</b>		13b. COUNTY <b>Cumberland</b>	13c. CITY OR TOWN <b>Lemoyne</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>232 Herman Avenue,</b>			
14. FATHER'S NAME <b>John</b>		15. MOTHER'S MAIDEN NAME <b>Ida</b>		16. SOCIAL SECURITY NO. <b>166-03-0260</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>166-03-0260</b>		17. INFORMANT <b>Musselman Funeral Home-Lemoyne, Penna.,</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pv) monary edema</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) <b>Arteriosclerotic Heart Disease with CHF</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>CHF</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 mos</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> 19 <b>80</b> to <b>7/15</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/15</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.								
22b. SIGNATURE <b>David Cromwell MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/16/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Cromwell, MD</b>				22e. ADDRESS <b>831 University Blvd., Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-18-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Centerville Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centerville Cumberland Penna.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, reverse retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 4 8 1	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JAMES FRANKLIN BEHELER					2a. DATE OF DEATH MONTH DAY YEAR 7/15/80					2b. HOUR 12 <sup>30</sup> A M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Apr 20, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Navy			
13a. STATE Maryland					13b. CITY OR TOWN Lanham		13c. STREET ADDRESS 6413 Princess Garden Pkwy				
14 FATHER'S NAME FIRST MIDDLE LAST Zed A Beheler					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esta Lilly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS Frances L. Behelet Same as # 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) <u>let Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatocellular Carcinoma</u> 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 24 hours 6 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cirrhosis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>15 April</u> 19 <u>80</u> , to <u>15 July</u> 19 <u>80</u> , that (I) (we) last saw (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE Thomas A. Beisinger MD DEGREE THOMAS A. BEISINGER MD										23b. DATE SIGNED 7/15/80	
23c. ADDRESS 1876 New Hampshire Ave 833 University Blvd E. S Pratt, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 18 JUL 80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood, Md.		23e. DATE REG'D. BY REGISTRAR JUL 21 1980			
24 FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801										25a. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 8 2

1 - STATE REGISTRAR		FOR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR	
Olga - Belkin				July 24, 1980	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
Female		White		May 22, 1907	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Russia		Russia		73 YRS	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
Takoma Park		Washington Adventist Hosp.		Montgomery MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. COUNTY		12c. CITY OR TOWN	
Maryland		Pr. Geo.		Hyattsville	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Yakov Ayzenshtadt		Tsipa Krasinskaya		13e STREET ADDRESS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		213-94-0745AS		Abram Belkin; 8220-14th Ave, Hyattsville, Md.	
18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) LUNG CANCER, METASTATIC TO BRAIN BONES + PLEURA					PROB. 8 MO.
1629 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/23 19 80 to 7/24 19 80, that (I) (we) lost saw the deceased alive on 7/24 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph B. Mizzgerd, MD				22c. DATE SIGNED 7/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH B. MIZGERD				22e. ADDRESS WASH. ADV. HOSP. TAKOMA PARK MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-27-1980		23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emes Cem.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		24b. ADDRESS Rockville, Md.		24c. LOCATION CITY OR TOWN COUNTY STATE Capitol Heights, Maryland	

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 4 8 3

1. DECEASED NAME (TYPE OR PRINT) <b>Jerry Lee Bennett</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 4 19 80</b>			2b. HOUR M <b>10:59</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7, 1957</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>22</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 4 19 80</b>	7d. HOUR M <b>10:59</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Rolling Acres</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Turf Farm</b>						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>12316 Judson Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Foster Bennett</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lora (Sister) Dolly</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		17. INFORMANT <b>Loretta Bennett</b> ADDRESS <b>Same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple visceral and skeletal injuries</b> 8052 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <b>11:55</b> P.M. MONTH DAY YEAR <b>6 4 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject struck by train</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>railroad tracks</b>		21f. LOCATION STREET <b>B &amp; O Railroad</b> CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/5/80</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 7 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spruce Mountain Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Onego</b> COUNTY <b>West Virginia</b> STATE <b>WV</b>	
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service</b>			ADDRESS <b>Fairfax, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1980</b>	
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

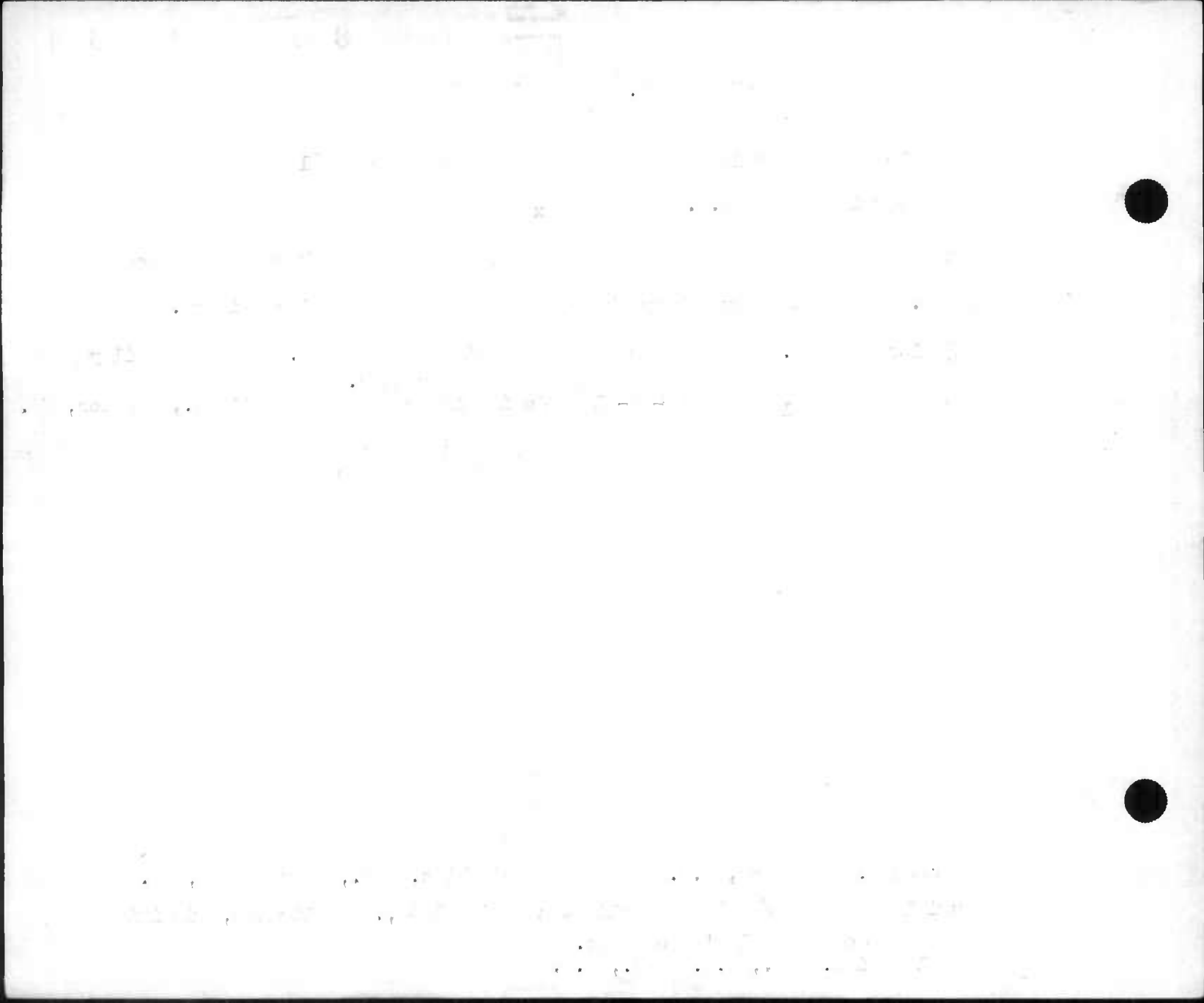
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 4 8 4

REG NO

1 DECEASED NAME (TYPE OR PRINT) Beverly R. Berney		2a. DATE OF DEATH MONTH DAY YEAR 7 11 80		2b. HOUR 10 <sup>32</sup> A.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 8 18 98		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Md.		13b COUNTY Montgomery	13c CITY OR TOWN Chevy Chase	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles N. Peek		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina G. Railey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO 579-42-3168		17 INFORMANT Daughter. Julia Linderman 3930 Isbell St., Wheaton, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of branch of Left Internal Carotid 431- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis 4 days DUE TO, OR AS A CONSEQUENCE OF (c) years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from March 19 75 to July 11 19 80, that (I) (we) last saw the deceased alive on July 11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John F. Gustafson		DEGREE M.D.		22c. DATE SIGNED 7-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Gustafson, M.D.		22e. ADDRESS 5480 Wisc. Ave., Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/15/1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
23d. LOCATION CITY OR TOWN Arlington, Virginia		23e. COUNTY Virginia		23f. STATE	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.		24b. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR JUL 17 1980	
25b. REGISTRAR'S SIGNATURE Rickey McCreary					



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 8 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST E. Lucille Berns			2a DATE OF DEATH MONTH DAY YEAR July 20, 1980		2b HOUR 4:37 pm	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1912		
6 AGE (IN YEARS LAST BIRTHDAY) 67		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? United States		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD				
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse NIH		
12b KIND OF BUSINESS OR INDUSTRY US Gov't						
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 10000 Brunswick Avenue				
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Perry			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zula Jane Winstead			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b SOCIAL SECURITY NO. 579 42 2376		17 INFORMANT ADDRESS 8715 Persimmon Leslie B. Hammond Tree Rd. Pot., Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 430 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 days</u> <u>20 years</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>7/15</u> 19 <u>85</u> , to <u>7/20</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Thomas F. O'Connor</u> M.D. DEGREE				22c DATE SIGNED July 21, 1980		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. O'Connor, M.D.				22e ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE July 23, 1980		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		
23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland						
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a DATE REC'D. BY REGISTRAR JUL 22 1980		
				25b REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		

The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 4 8 6

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY K. BINDER										2b. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 20 1980		2b. HOUR M 2:59 a.m.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 7, 1922		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 57		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 6 20 19 80		2d. HOUR a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? U. S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Communication				12b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.			
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13900 Broomall Lane					
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Kassack				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Etkins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Wheaton, Md. Daniel Binder 13900 Broomall Lane									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Anorexia nervosa														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30 6-20- 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Apparently fell down stairs.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13900 Broomall Lane, Silver Spring, Mont. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														Re-issued 8-18-80	
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER 111 Penn St.				DATE SIGNED 6-20-80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jun, 22, '80		23c. NAME OF CEMETERY OR CREMATORY Mt. Sharon				23d. LOCATION CITY OR TOWN COUNTY STATE Delaware Pa.					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg, Inc, 1170 Rockville				ADDRESS Rockville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 25 1980				25b. REGISTRAR'S SIGNATURE Dorothy McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NATHAN BISBERG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27, 1980</b>		2b. HOUR <b>4:30 a.m.</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar 22, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Potomac</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10305 Bells Mill Terrace</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manufacturer (ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Wear</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Bisberg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah (unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>086-03-7038</b>		17. INFORMANT ADDRESS <b>Mr. Cohen; 10305 Bells Mill Terr, Potomac, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal insufficiency</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>6 years</b> <b>4 years</b>	
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 80</b> to <b>July 27 80</b> , that (I) (we) last saw the deceased alive on <b>July 25 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John Evans</b> DEGREE <b>MD</b>								22c. DATE SIGNED <b>7-27-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN M. EVANS, MD.</b>								22e. ADDRESS <b>5480 Wisconsin Ave., Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Israel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hartford, Connecticut</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels;</b>				ADDRESS <b>1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1881-08

Account of Travel in Japan  
and  
Account of Travel in China

Japan - 1881-82  
China - 1882-83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 4 8 8			
1- STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ESTHER		G.		BOSSHARD		7/5/80		7		5		80 1230 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		1 24 1894		86		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Kansas		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Bethesda Health Care Center		Bookkeeper - Retired									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5721 Grosvenor Lane					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
William		Emma											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
No		Yes		Shirley Grossman		1471 Palwood Drive							
						Sarasota, Florida 33582							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Acute cardiovascular arrest</i>										Sudden			
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery heart disease</i>										10 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from 7/5 80/6 to 7/5 80, that (I) (we) lost saw the deceased alive on 7/5 80/6, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
MYRON L. LENKIN				7/5/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
MYRON L. LENKIN		2309 SHOREFIELD RD WHEATON MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Cremation		7-6-80		Metropolitan Crematory		Alexandria		COUNTY		Virginia			
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Tyson Wheeler Funeral Home, Inc.		JUL 11 1980											
1354 Rockville Pike Rockville, Md. 20852													

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Bethesda Health Care Center

Bethesda

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Montgomery Bethesda

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Chicago, Illinois 60604

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8018489

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD EARL BRADFIELD		2. DATE OF DEATH MONTH DAY YEAR JULY 19, 1980 9 P M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC. 16, 1944	6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost Engineer 12b. KIND OF BUSINESS OR INDUSTRY Bechtel Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE TEXAS 13b. COUNTY Titus 13c. CITY OR TOWN MT. PLEASANT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 106 EAST HOLLAND St.	
14. FATHER'S NAME FIRST MIDDLE LAST Luther E. Bradfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pat Tucker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam 459-70-6054		17. INFORMANT ADDRESS MRS. BRENDA BRADFIELD (NOK) SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>MULTIPLE ORGAN SYSTEM DYSFUNCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>BURKITT'S LYMPHOMA</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>MAY 24, 1980</u> to <u>JULY 19, 1980</u> , that (1) (we) last saw the deceased alive on <u>JULY 19, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (and not) view the body after death.			
22b. SIGNATURE BRIAN J. CORBEN		22c. DATE SIGNED 7/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN J. CORBEN		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/80	
23c. NAME OF CEMETERY OR CREMATORY Edwards Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Pleasant Titus Texas	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR JUL 23 1980	
25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 0 1 8 4 9 0									
1 - FOR STATE REGISTRAR									
REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William E. Brewster					2r. DATE OF DEATH MONTH DAY YEAR 7/22/80				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. HOUR 38 M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Budget Officer		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spg.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Edwards Pierpont Brewster		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Peene				13e STREET ADDRESS 613 Hollywood Avenue			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 251-44-5321		17 INFORMANT Suzanne B. Roethel				ADDRESS 1216 Brantford Ave Silver Spring, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7561 Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Kyphoscoliosis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: Days since birth									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 16, 1980, to July 22, 1980, that (I) (we) last saw the deceased alive on July 16, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Patricia D. Kellogg MD				DEGREE MD		22c. DATE SIGNED 7/22/80		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA D. KELLOGG				22e ADDRESS 809 Viers Mill Rd, Rockville, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/28/80		23c NAME OF CEMETERY OR CREMATORY N. Cornwall Cem.		23d LOCATION CITY OR TOWN COUNTY STATE North Cornwall, Conn.			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 29 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18491	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>CLYDE ALLEN BRITTON</b>						2a. DATE OF DEATH <input checked="" type="checkbox"/> KNOWN <input type="checkbox"/> ESTIMATED <b>7-14 1980</b>		2b. HOUR <b>1:13 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 11, 1943</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>July 14 1980</b>		7d. HOUR <b>1:13 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 270 - near Mont. Village</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hauling Co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>106 N. Summit Ave.</b>	
14. FATHER'S NAME <b>Louis A. Britton</b>						15. MOTHER'S MAIDEN NAME <b>Hilda J. Gaither</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-42-2627</b>		17. INFORMANT ADDRESS <b>Agnes Gaither Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries Severe -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pedestrian - Auto Trauma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>12:50 - 7-14 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Struck by Two Autos. When ditch digging.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Route 270 - near Mont Village.</b>		21f. LOCATION <b>Gaithersburg Montgomery Md</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>July 14, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 16, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cem.</b>		23d. LOCATION <b>Gaithersburg Mont. Md.</b>			
24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER LAYTONSVILLE, MD. 20760</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b. REGISTRAR'S SIGNATURE <b>H. McCreedy</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DISEASE OR INJURY IS SUSPECTED. IF THE DEATH IS NATURAL, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETURNED TO THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18492	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
3. DECEASED NAME (TYPE OR PRINT) LOUIS BRODSKY										2b. HOUR 1:20am	
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH Jan 19, 1909		6. AGE (IN YEARS) 71 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD JULY 13, 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Silver Spring,		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRANSPORTATION		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1131 University Blvd West #1017			
14. FATHER'S NAME JOSEPH BRODSKY				15. MOTHER'S MAIDEN NAME SARAH RIMMERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-01-1053		17. INFORMANT ADDRESS LILLIAN B. BRODSKY, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hemorrhage Probable gastric											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Peptic Ulcer											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Advanced Chronic Obstructive Pul Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard L. Whelton				TITLE (SPECIFY) MEDICAL EXAMINER				DATE SIGNED July 13, 1980			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON				ADDRESS 7100 Balt Ave College Park Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 7/15/1980		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CAPITOL HEIGHTS, PR. GEO., MD.			
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL F. H. 232 CARROLL STREET, N. W., WASHINGTON, D. C.											
DATE RECD. BY REGISTRAR JUL 17 1980 REGISTRAR'S SIGNATURE Anthony McCready											

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis Calvert Brooke, Jr.			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1980			2b. HOUR 1:05 P M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3422 Manor Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Calvert Brooke, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-4179		17 INFORMANT ADDRESS Mrs. Mildred M. Brooke Same as item #13			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of cervical esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 month 8 months
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION Nov 1977		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED total esophageal obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>76</u> to <u>present</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William M. Tribble</u>				DEGREE MD		22c. DATE SIGNED 23 July 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William M. Tribble, M.D.				22e. ADDRESS 1234 19th Street, N.W. Wash., D.C.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Warrenton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Warrenton Virginia	
24 FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE <u>notary</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80108

JUL 2 1980



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8018494									
1. FOR STATE REGISTRAR												2a. DATE KNOWN OF DEATH		2b. DATE OF ESTIMATE							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edwin P. Broomall, Sr.</b>												MONTH DAY YEAR <b>07 29 80</b>		HOUR MIN <b>3:51 A M</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Apr 19 04</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>72 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE - PRONOUNCED DEAD <b>07 29 80</b>		24. HOUR MIN <b>3:51 A M</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>									
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer Self-Employed</b>				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE <b>Md</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Silver Spg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>15012 Candler Dr</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas W. Broomall</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet M. Gautier</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>						16b. SOCIAL SECURITY NO. <b>150-09-4653</b>		17. INFORMANT <b>Wife Kathryn J. Broomall</b>				ADDRESS <b>same as 13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis.</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>												TITLE (SPECIFY) <b>M.D. Dep</b>		MEDICAL EXAMINER		DATE SIGNED <b>July 29 1980</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>												ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jul. 31, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Mont. Md.</b>											
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>								25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1980</b>				25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>									
500 University Blvd., W. Silver Spring, Md.																					

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*Wm. L. Mumford*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 1 8 4 9 5  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT IRVIN BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 17, 1980</b>		2b. HOUR <b>10:50 P.M.</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>SEPT 11, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10 CITY OR TOWN OF DEATH <b>WHEATON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RANDOLPH HILLS NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>T.B.F.W.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11614 VIERS MILL ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM H. BROWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE WALSH</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>			
17. SOCIAL SECURITY NO. <b>578-05-8315</b>			18. INFORMANT <b>DAUGHTER</b>			ADDRESS <b>2308 CONTEST LANE HAYMARKET, VIRGINIA</b>			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the lung 6 mos</b> 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <b>Benign Prostatic Hyperplasia 6 mos</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>17 Jul 19 80</b> to <b>17 Jul 19 80</b> , that (I) (we) last saw the deceased alive on <b>17 Jul 19 80</b> , and that in my (our) opinion death occurred on the date and hour and (from the cause stated) above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ALAN I. KERMAIER, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		DATE SIGNED <b>18 Jul 80</b>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN I. KERMAIER, MD</b>		22d. ADDRESS <b>9501 Georgia Ave. SE. Md 20861</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D. C.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>			
26. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>									



10:50P JULY 17, 1980

WHITE SHEET 11 1980

MONTGOMERY F. C. M. A. X

WHEATON TANDOLPH MILLS MONTGOMERY ELECTRICIAN I.H.E.W.

MONTGOMERY SILVER SPRING X

WILLIAM H. BROWN CATHETER

2001 COMPTON LANE  
HARRISBURG, VIRGINIA  
773-65-1215 RITA C. BLAIR

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M. A. Blair  
Catheter

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M. A. Blair

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M. A. Blair

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18496

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH	MIDDLE FRANKLIN	LAST BURROWS	SR.	2a. DATE OF DEATH MONTH DAY YEAR July 9, 1980	2b. HOUR 7:05P M
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 21, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Operator		12b. KIND OF BUSINESS OR INDUSTRY Hotel-Supply	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland	13b. COUNTY Mont.	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8630 Brink Road			
14. FATHER'S NAME FIRST MIDDLE LAST William F. Burrows			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Curran				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-10-6197		17. INFORMANT ADDRESS Anna May Burrows Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 1520 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (Gt + Med)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>La Buerger's Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7d</u> <u>6 wks</u> <u>3 mos</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>20 June 80</u> to <u>9 July 80</u> , that (I) (we) last saw the deceased alive on <u>20 June 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Paul Noone</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 July 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Noone		22e. ADDRESS 50W. Edmonston Dr. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760				25a. DATE RECEIVED BY REGISTRAR JUL 15 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 18497			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAVOLDA P BURTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7-18-80</b>		2b. HOUR <b>9:26 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 9, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>45</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>4516 Usange Street</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>John Bogle</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO <b>213 24 4184 J1</b>		17. INFORMANT ADDRESS <b>Nancy Sweeney same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> <b>4019</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertension. CARDIOMEGALY</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe decubital ulcer</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-05</b> 19 <b>80</b> to <b>7-18</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7-18</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Veronica Troost MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-19-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VERONICA TROOST MD</b>				22e. ADDRESS <b>10236 NEW HAMPSHIRE AVE. SS.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 21, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtons ville, Md</b>	
24. FUNERAL DIRECTOR <b>Donald J. H.</b>				25a. DATE REC'D BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Pietro Maloney</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 9 8

REG. NO.

FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Laura L. Burwell</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 26, 1980</b>		2b HOUR <b>6:29P<sub>M</sub></b>				
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 26, 1925</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>704 Malibu Drive</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>---</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Sil. Sprg.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>704 Malibu Drive</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Willie Monger</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Cooper</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>229-22-5943</b>		17 INFORMANT <b>Wadell Burwell, Husband</b>		ADDRESS <b>SAA</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEIOMYOSARCOMA of UTERUS</b> <b>179-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 19 79</b> , to <b>7-26</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7-19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>L. McGowan, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>7-28-80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. McGowan, M.D.</b>				22e ADDRESS <b>2150 Penna. Ave., N.W. Wash., D.C.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>7/30/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Suffolk, Virginia</b>			
24 FUNERAL DIRECTOR <b>McGuire Funeral Service, Inc.</b> <b>7400 Ga. Ave., N.W.</b>				25a DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 4 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emma F. Butler</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 7 1980</i>		2b. HOUR <i>8:10 P</i>
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 28 1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Collingswood Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housekeeping</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Montg.</i>	13c. CITY OR TOWN <i>Damascus</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>9430 Holsey Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John H. Holsey</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Heddie Potts</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219 05 2746</i>		17. INFORMANT <i>Lillie Holsey</i> ADDRESS <i>9453 Holsey Road Damascus, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Artery</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arterio-sclerotic Cardio Vascular Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/7/80</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/7/80</i> 19 <i>80</i> to <i>7/7/80</i> 19 <i>80</i> , that (I) <del>lost</del> saw the deceased alive on <i>7/7/80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <i>did not</i> view the body after death.					
22b. SIGNATURE <i>Milton D. Westberg M.D.</i>				22c. DATE SIGNED <i>7/7/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Milton D. Westberg M.D.</i>				22e. ADDRESS <i>2 Professional Drive Gaithersburg Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 10, 80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Friendship Ceme.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Damascus Montg. Md.</i>		23e. DATE REC'D. BY REGISTRAR <i>JUL 15 1980</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Olin L. Molesworth, PA Damascus, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Larry A. Brady</i>			

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Items 18 & 22a G547 9/4/80 dad STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret Rose Carey</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>7 23 1980</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jun. 14 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>65</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 23 1980</b>		7d. HOUR M <b>AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8 Hilltop Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8 Hilltop Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander McCormick</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Johannah Melcher</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>324-01-1201</b>		17. INFORMANT <b>Guardian George G. Higgins</b>				ADDRESS <b>1312 Mass. Ave. N.E. Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiomyopathy</b> 4254 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>H R Guard</b>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER				DATE SIGNED <b>7-24-80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jul. 26, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						ADDRESS <b>500 University Blvd. W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 0 1

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Warren H. Carter		2a. DATE OF DEATH MONTH DAY YEAR July 31, 1980		2b. HOUR 8:30 PM	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Policeman		12b. KIND OF BUSINESS OR INDUSTRY Montg. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clifton Carter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Sharpe		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	
17. INFORMANT Jane Carter		18. ADDRESS Same as 13		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Anti-coagulated for recent myocardial infarct</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (the hospital) attended the deceased from <u>May 5</u> , 19 <u>80</u> , to <u>July 31</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Russell M. Tilley, Jr., M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED August 1, 1980		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, Jr., M.D.		22e. ADDRESS 4701 Massachusetts Ave. NW Wash. D.C.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE Aug. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.		24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND	
25a. DATE AUG 6 1980		25b. BY REGISTRAR <input checked="" type="checkbox"/> REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. BY REGISTRAR <input type="checkbox"/>		25d. BY REGISTRAR <input type="checkbox"/>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 8 5 0 2		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>Patricia Ann Caster</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 15, 1980</b>		2b. HOUR <b>8:15 P M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 16, 1939</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, Bethesda, Md</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Consulting</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Bethesda</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur Budd</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Sosnoski</b>		13e STREET ADDRESS <b>7608 Westlake Terrace</b>		20034	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>272-34-8317</b>		17 INFORMANT <b>Mr. Edgar Caster (husband)</b>		ADDRESS <b>Same as 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE GASTROINTESTINAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MALIGNANT MELANOMA</b> 6 MOS DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 30</b> , 19 <b>80</b> , to <b>July 15</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 15</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <b>B. C. Key</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>July 16, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DOUGLAS BLAYNEY</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		24b. ADDRESS <b>Homes, P.A.</b>		24c. DATE <b>July 19, 1980</b>		24d. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "TABLE" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Francis N. CLARK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 29 1980</b>		2b. HOUR <b>3:58 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 22, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Foreman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>W S S C</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>Md</b>	13b. COUNTY <b>Pro Georges</b>	13c. CITY OR TOWN <b>Beltsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earnest Clark</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta Norris</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577 10 3984</b>	17. INFORMANT ADDRESS <b>Dorothy M Clark Beltsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Emphysema</b>				
19a. DATE OF OPERATION <b>7/29</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>831 University Blvd. E., Sil. Spr., MD.</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>5/3/80</b> 19 <b>80</b> , to <b>7/29</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/29</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22a. SIGNATURE <b>Lewis H. Dennis</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/30/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis H. Dennis, M.D.</b>		22e. ADDRESS <b>831 University Blvd. E., Sil. Spr., MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug 2, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>	25b. REGISTRAR'S SIGNATURE <b>Henry K. [Signature]</b>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18504	
1. DECEASED NAME (TYPE OR PRINT) <b>James D. Clark</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 4 19 80		2b. HOUR M 1:30 A M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 14 '36</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>43</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 5 19 80</b>	2d. HOUR <b>1:30 A M</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>426 E. Diamond Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dry Wall Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>426 E. Diamond Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Robert Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christine Anna Biddinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-32-8849</b>		17. INFORMANT ADDRESS <b>2901 Fairland Rd. Mary Elizabeth Biser Silver, Spring, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> 7999 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>Assistant</b>				M.D.		DATE SIGNED <b>7/5/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street, Baltimore, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 8, '80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Libertytown Frederick Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F. H. Gaithersburg, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 14 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Richard A. Bandy</i>					

8 1 0 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM H CLIFFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 8 1980</b>		2b. HOUR <b>5<sup>00</sup> A.M.</b>		
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 9 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>57</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3922 MINDEN RD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Designing Engr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Tel. Co.</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3922 MINDEN RD.</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Clifford</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>L. Katharine Hoffman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE YEAR OR DATES) <b>577-26-6462</b>		17. INFORMANT ADDRESS <b>Catharine B. Clifford (same as 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> 19 <b>77</b> , to <b>7/8</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/8</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Myron L. Lenkin</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/8/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>		22e. ADDRESS <b>2309 SHOREFIELD RD WILKINSON MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>JULY 9, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREM.</b>		23d. LOCATION <b>ALEXANDRIA FAIRFAX VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1980</b>		25b. REGISTRAR'S SIGNATURE <b>notary already</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0905 BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 8 5 0 6			
1 - STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROL - COLE				2a DATE OF DEATH MONTH DAY YEAR 7-22-80			
3 SEX Female				2b HOUR 7:00 PM			
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Apr. 3, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7a CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proof Reader		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland				13c CITY OR TOWN Rockville		13d STREET ADDRESS 252 Congressional Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Adolph Scharfstein				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie (unknown)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 088-05-4248B		17 INFORMANT ADDRESS Mr. Jacob Cole Rockville, Md. La.			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 1 MONTH 1 YEAR							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from July 23, 1980, to July 22, 1980, that (I) (we) last saw the deceased alive on July 23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE J. L. L. WARD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/22/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. L. L. WARD		22e ADDRESS 6116 Rockville, Bethesda 20034					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-25-80		23c NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Md. Montgomery	
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels		ADDRESS Rockville Md.		25a DATE REC'D. BY REGISTRAR JULY 28 1980		25b REGISTRAR'S SIGNATURE	

00818

CHARTER

00818 JUL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 0 1 1 8 5 0 7	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>James A. Condry</b>					2a. DATE KNOWN OF DEATH MONTH <b>7</b> DAY <b>31</b> YEAR <b>1980</b>			2b. HOUR <b>3:22</b> P M			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>9</b> YEAR <b>07</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <b>July 31</b> 19 <b>80</b>			2d. HOUR <b>3:22</b> P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dentist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>400 Southwest Drive</b>			
14. FATHER'S NAME FIRST <b>Patrick</b> MIDDLE <b>J.</b> LAST <b>Condry</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Teresa</b> MIDDLE <b>Gill</b> LAST <b>Gill</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b>			16b. SOCIAL SECURITY NO. <b>236 20 4269</b>		17. INFORMANT ADDRESS <b>Same as above</b> <b>Elizabeth Condry (Wife)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Fracture L. Hip</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Hrs.</b> <b>15 Days</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>7 16 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fall At Home</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>400 Southwest Dr.</b> CITY OR TOWN <b>Sil. Spring</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dr. John S. Rogers</i>			TITLE (SPECIFY) M.D. <i>Dr. John S. Rogers</i>			MEDICAL EXAMINER		DATE SIGNED <b>Aug-1, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. John S. Rogers</b>			ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/2/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem</b>		23d. LOCATION CITY OR TOWN <b>S.S.</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>			ADDRESS <b>11800 N.H.Ave. S.S.Md.</b>			AUG 6 1980 RECORDED BY REGISTRAR					

CSCI 320A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8018508

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST <i>Brita</i> MIDDLE <i>Counselman</i> LAST <i>Counselman</i>		2a DATE OF DEATH MONTH <i>July</i> DAY <i>7</i> YEAR <i>80</i> 2b HOUR <i>1300 A.M.</i>	
3 SEX <i>female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH MONTH <i>7</i> DAY <i>18</i> YEAR <i>1890</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>California</i>	7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10 CITY OR TOWN OF DEATH <i>Bethesda, MD.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>owner</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>antique shop</i>
13a STATE <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Gaithersburg</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST <i>unknown</i> MIDDLE <i>Dybergh</i> LAST <i>Dybergh</i>		15 MOTHER'S MAIDEN NAME FIRST <i>Ada</i> MIDDLE <i>Fredlund</i> LAST <i>Fredlund</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO <i>215-52-5974</i>	
17 INFORMANT <i>Dr. Robert Day</i>		ADDRESS <i>103 Walnut St., Middleburg, Va.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6/19</i> <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/19</i> <i>19</i> <i>80</i> to <i>7/6</i> <i>19</i> <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/6</i> <i>19</i> <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <i>James T. Brodsky MD</i>		22c. DATE SIGNED <i>7-6-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Brodsky MD</i>		22e. ADDRESS <i>4701 Willard Ave Chevy Chase</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>July 7, 1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Prince Georges, Md.</i>
24 FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons, Inc.</i> <i>5130 Wisconsin Ave., N. W., Wash., D. C. 20016</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 11 1980</i>	
25b. REGISTRAR'S SIGNATURE <i>James T. Brodsky</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 5 0 9	
1 - FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bonnie Mae COX</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 31 1980</b>			2b. HOUR <b>1:20P M</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 9, 1943</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cresaptown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 5, Craddock Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Charles Martin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Mae Keidel</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 42 7111</b>		17. INFORMANT <b>Donald R. Cox</b>				ADDRESS <b>See item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>3949</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral Valve replacement, severe hemolysis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Clotted Mitral Valve Prosthesis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>30 days</b> <b>32 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>Renal Failure</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (✓) (this hospital) attended the deceased from <b>June 24</b> , 19 <b>80</b> , to <b>July 31</b> , 1980, that (✓) (we) lost saw the deceased alive on <b>July 31</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (✓) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michael Swank</i> M.D. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>July 31 1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Swank, M.D.</b>						22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>				23b. DATE <b>Aug. 3, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b> ADDRESS <b>202 Greene St. Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18510

1. DECEASED NAME (TYPE OR PRINT)		FIRST Lewis		MIDDLE B.		LAST Craver		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 6		DAY 24		YEAR 1980		2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1906		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 6		DAY 24		YEAR 1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		MD.			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1923 Henry Rd., Rockville, Md.		14. FATHER'S NAME FIRST MIDDLE LAST Wm. Craver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Lare		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-28-2001B1		17. INFORMANT Margaret V. Craver same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) Acute gastric hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Arteriosclerotic cardiovascular disease																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE H. R. Guard				TITLE (SPECIFY) Assistant				M.D. MEDICAL EXAMINER				DATE SIGNED 6/24/80							
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD				ADDRESS 111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/27/1980				23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.							
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				25a. DATE REC'D. BY REGISTRAR JUN 30 1980				25b. REGISTRAR'S SIGNATURE Happy Reddy											

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, these 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 1 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IRENE NMN CREECY		2a. DATE OF DEATH MONTH DAY YEAR 7/16/80		2b. HOUR 10 <sup>35</sup> P.M.	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JAN. 7, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WESLEY JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH MCABEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-44-4774		17. INFORMANT ADDRESS ESSIE BUDD - 405 W. DIAMOND AVE GAITHERSBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myeloproliferative Disorder 2387 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sepsis; Hemorrhage					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 1980 to July 16 1980, that (I) (we) lost saw the deceased alive on July 16 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph E. Smith, Jr. M.D.				22c. DATE SIGNED 7/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph E. Smith, Jr. M.D.				22e. ADDRESS 4140 Sandy Springs Rd. Burrville, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-23-80		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Montg. Md.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. WASH. Rockville, Md.		25. DATE REC'D. BY REGISTRAR JUL 25 1980	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Patsy McBrady		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 8 5 1 2		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Evelyn Iona Crigger				MONTH DAY YEAR 7 23 80				8 58 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS	
female		white		MONTH DAY YEAR 8 11 1919		60 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		USA				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital				Housewife		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE Maryland				13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. 100 East Argyle St. Apt. 9					
14. FATHER'S NAME FIRST MIDDLE LAST Herbert C. Christopher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie P. Malcolm							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
no --				254 30 4118A		Oscar H. Crigger same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Oscar-Werner-Rendu disease, Cerebral Vascular Thrombosis.</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25/</u> 19 <u>77</u> to <u>8/23/</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8/23/</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Robert C. Macon</u>				22c. DATE SIGNED 7/24/80				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon				22f. ADDRESS 809 Viers Mill Rd. Rockville, Md. 20851							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7/25/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE OF DEATH JUL 30 1980		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL/CLINIC ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 1 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lois Barrett Crown</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7-5-80</b>		2b HOUR <b>8 45 P.M.</b>						
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 3. 1883</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		7 UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8 UNDER 24 HRS. HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GEORGIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL ADVENTIST HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PUBLISHING HOUSE R. &amp; H.</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>			13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>TAKOMA PARK</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>8011 MAPLE AVENUE</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>BACRETT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE ?</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS <b>GLORIA PENNINGTON 8011 MAPLE AVE T.P.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>2765</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration, dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>greater than 1 year</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>7/3</b> 19 <b>80</b> , to <b>7/5</b> 19 <b>80</b> , (that) (we) last saw the deceased alive on <b>7/5/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Deborah B. Goldberg</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>7/6/80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DEBORAH B GOLDBERG</b>			22e ADDRESS <b>MARYLAND 1106 SPRING ST SILVER SPRING</b>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>July 9, 1980</b>			23c NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington DC</b>		
24 FUNERAL DIRECTOR NAME <b>Takoma Funeral Home</b>			ADDRESS <b>251 Carroll St NW</b>			DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>			REGISTRAR'S SIGNATURE <b>Anthony [Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 0 1 8 5 1 4							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Madeline V Crowson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 5 1980</b>		2b. HOUR <b>1215P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 12 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <del>XXXXXX</del> <b>77</b> YRS		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Camberland md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>816 Easley St # 423</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Edward Moore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Fleming</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>577-50-9677</b>		17. INFORMANT (husband) ADDRESS <b>Charles A. Crowson-(same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Paroxysmal Tachycardia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>80</b> , to <b>July</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David B. Simon, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>July 5, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David B. Simon, M.D.</b>				22e. ADDRESS <b>916-19th St., N.W. Washington, D.C. 20006</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-8-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery MD</b>			
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Clark E. Wilson</b>			
24. ADDRESS <b>8434 Ga. Ave., S.S. Md.</b>									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 1 5  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Lillia P Cryer		MONTH DAY YEAR 7-25-80	
3 SEX Female		2b. HOUR 4:15 A	
4 RACE White		5. DATE OF BIRTH	
MONTH DAY YEAR April 7 1884		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Del Pre Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Prince Georges Marlow Heights	
14. FATHER'S NAME FIRST MIDDLE LAST John Palmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Creighton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-3319	
17. INFORMANT Lillia P Pogue		ADDRESS 2600 Keating St. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of Breast (a)</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>7-25</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>6-22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Jack Schumacher M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 7-25-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher M.D.	
22e. ADDRESS 105 Russell Ave., Gaithersburg, Md. 20878			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/80	
23c. NAME OF CEMETERY OR CREMATORY All Saint Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakley St Mary Ar.	
24. FUNERAL DIRECTOR NAME George P. Alast. H. G. 6000 #11 Rq		25a. DATE REC'D. BY REGISTRAR JUL 29 1980	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 5 1 6	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST NATHAN		MIDDLE DAVIS		LAST DAVIS		2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1980		2b. HOUR 10:37 PM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 16, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE NURSING HOME WHEATON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY WHOLESALE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL DAVIS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA FEDER FELT'R					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 119-28-1316		17. INFORMANT ADDRESS SHERMAN L. DAVIS, BALTIMORE, MARYLAND 3501 ST. PAUL STREET							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 4 MOS. TO 1 YR. 4 YRS.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 24</u> 19 <u>80</u> to <u>JULY 14</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>JULY 10</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <u>Albert H. Grollman</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/15/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. ALBERT GROLLMAN, M. D.						22e. ADDRESS 1106 SPRING STREET, SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/17/1980		23c. NAME OF CEMETERY OR CREMATORY TEMPLE BETH DAVID CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BUFFALO NEW YORK					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.						25a. DATE RECEIVED BY REGISTRAR JUL 18 1980		25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 1 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY ANN Deegan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 19 1980</b>		2b. HOUR <b>2:27 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 19 1980</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN <b>1 43</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>N/A.</b>		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ELK RIDGE</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5P20 TIMBERVIEW DR.</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT J. DEEGAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAUREEN A. RYNNING</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>N/A.</b>		17. INFORMANT ADDRESS <b>ROBERT J. + MAUREEN A. DEEGAN</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immature Non Viable Fetus 20 wks</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gestation 2150gms</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7651</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. B. Berkowitz MD (H. B. Berkowitz)</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/20/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. B. BERKOWITZ</b>		22e. ADDRESS <b>6201 GREENBOLT RD #G7 COLLEGE PK MD 20740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>FLECK LAUREL FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. Kelly</b>	
26. ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>							

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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*[A small, distinct handwritten note or signature.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 1 8  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST <b>ANA II. DEJANOVIC</b>					MONTH DAY YEAR <b>7 2 80</b>					<b>4:50 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 15 1934</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>46 YRS.</b>			IF UNDER 1 YEAR MONTHS DAYS <b>46 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>YUGOSLAVIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSP</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES LADY</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8221 FLOWER AVENUE,</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>VLATIMIR FIALA</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MILKA GROMOVIC</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>282-48-0911</b>		17. INFORMANT ADDRESS <b>TRAGI DEJANOVIC (SAME AS #13 ABOVE)</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Restrictive cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>6 mo.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19</b> , 19 <b>80</b> , to <b>7/2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Keith M. Lindgren</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/2/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KEITH M. LINDGREN</b>						22e. ADDRESS <b>7600 CARROLL AVE, TAKOMA PARK, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>JULY 5 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>TAKOMA FUNL HOME</b>						24b. ADDRESS <b>354 CARROLL ST. N.W., WASH D.C. 20012</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Tracy K. Brady</b>	

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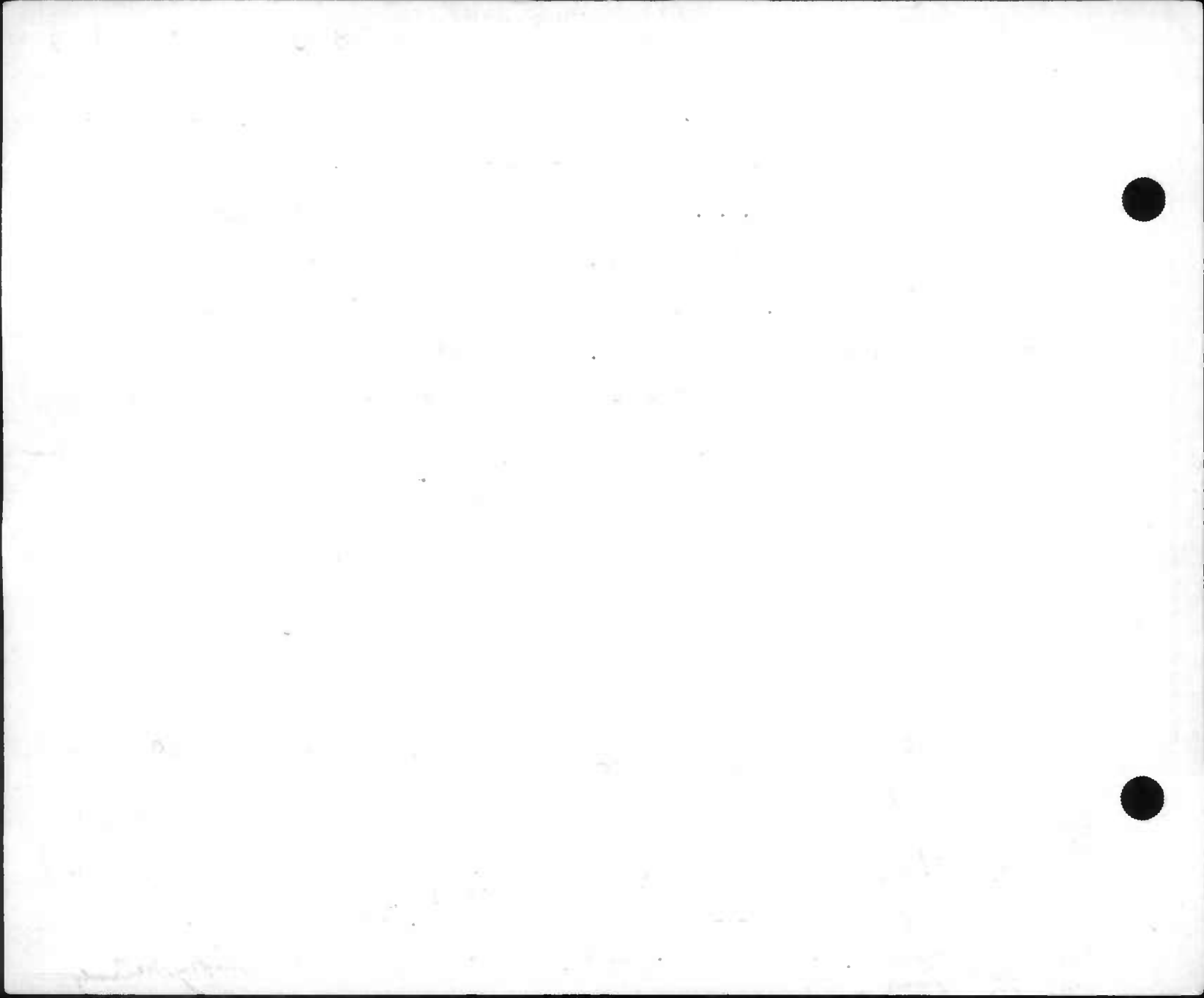
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18519

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna H. Demar			2a. DATE OF DEATH MONTH DAY YEAR July 4. 80		2b. HOUR 9: A M						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2- 22- 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Laytonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7440 Brink Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md		13b. COUNTY Montg.		13c. CITY OR TOWN Gaith		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7440 Brink Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Hillary Demar Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deliah Bowie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-3635		17. INFORMANT Mrs. Georgia Groomes (Niece)				Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>over 5 yrs.</u>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> 19 <u>79</u> , to <u>June 23</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>June 23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas P. Sloan</u> M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Sloan						22e. ADDRESS 9701 Church St. Damascus Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-8-1980		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville, Md			
24. FUNERAL DIRECTOR NAME George R. Snowden						24b. ADDRESS 246 Rockville, Md		25a. DATE REC'D. BY REGISTRAR JUL 9 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 2 0

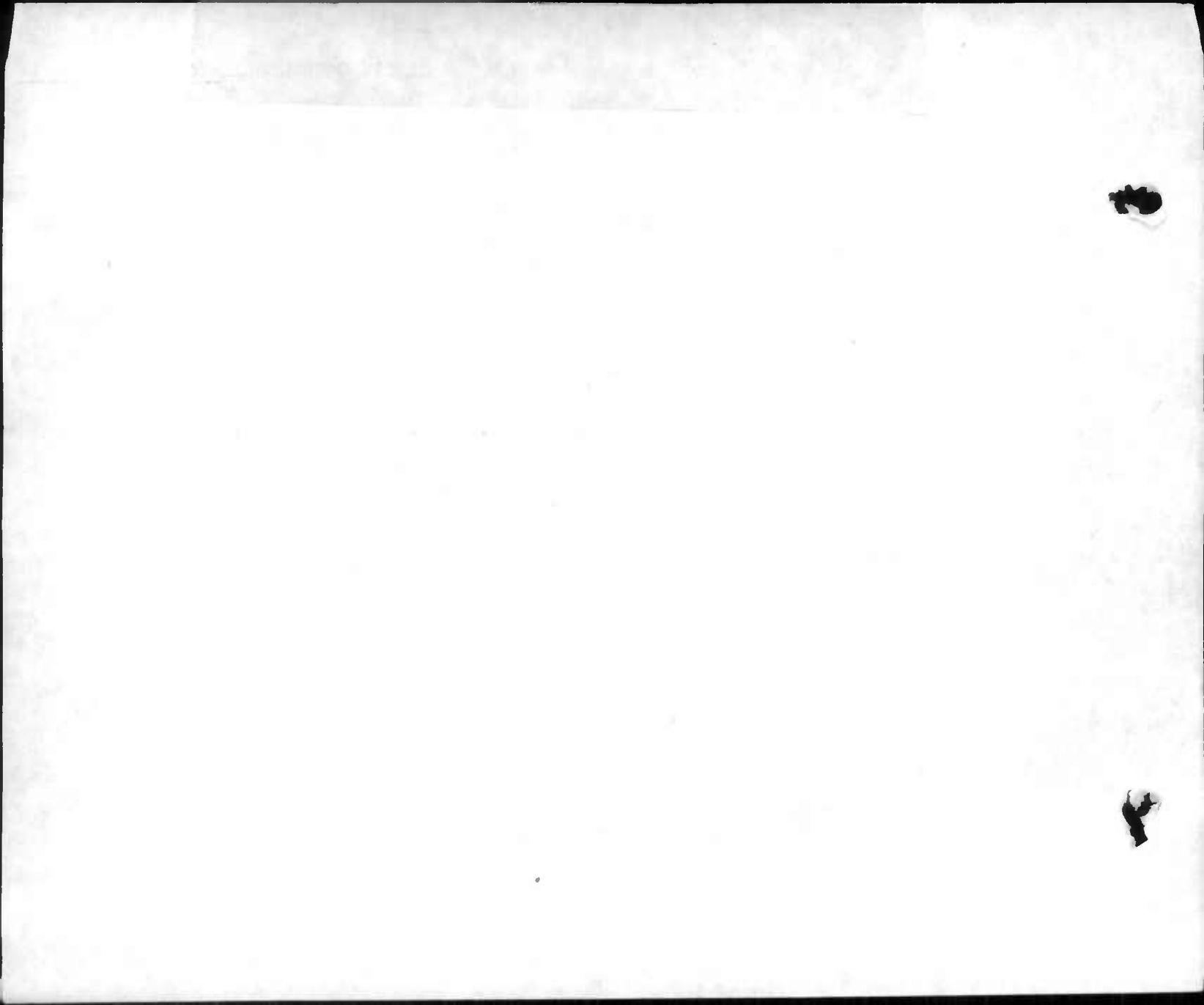
1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>HELEN</u> MIDDLE <u>J.</u> LAST <u>DEMAs</u>		2. DATE OF DEATH MONTH DAY YEAR July 27, 1980 9:15 AM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 22 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12. KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring
14 FATHER'S NAME FIRST MIDDLE LAST John Tarkados		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Mihas	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578-46-2675	17 INFORMANT (Husband) James Demas
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from <u>July 24</u> 19 <u>80</u> to <u>July 27</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 27</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>Edward J. Richards</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 7-28-80
22d PHYSICIAN'S NAME (TYPE OR PRINT) Edward J. Richards		22e ADDRESS 10301 Georgia Ave., Silver Spring, Md. 20902	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 7/30/80	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.
24 FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS 11800 N.H.Ave. Silver Spring, Md.	25a DATE REC'D. BY REGISTRAR JUL 30 1980
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

VOIDED DEATH CERTIFICATE NUMBER LISTED ABOVE  
DEATH CERTIFICATE, ACTUALLY A 1979 DEATH.

JEFFREY DEUGLWILLO, MAY 10, 1979, MONTGOMERY CO.

See Late 1979 Deaths.





TO HOSPITAL SURGEON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

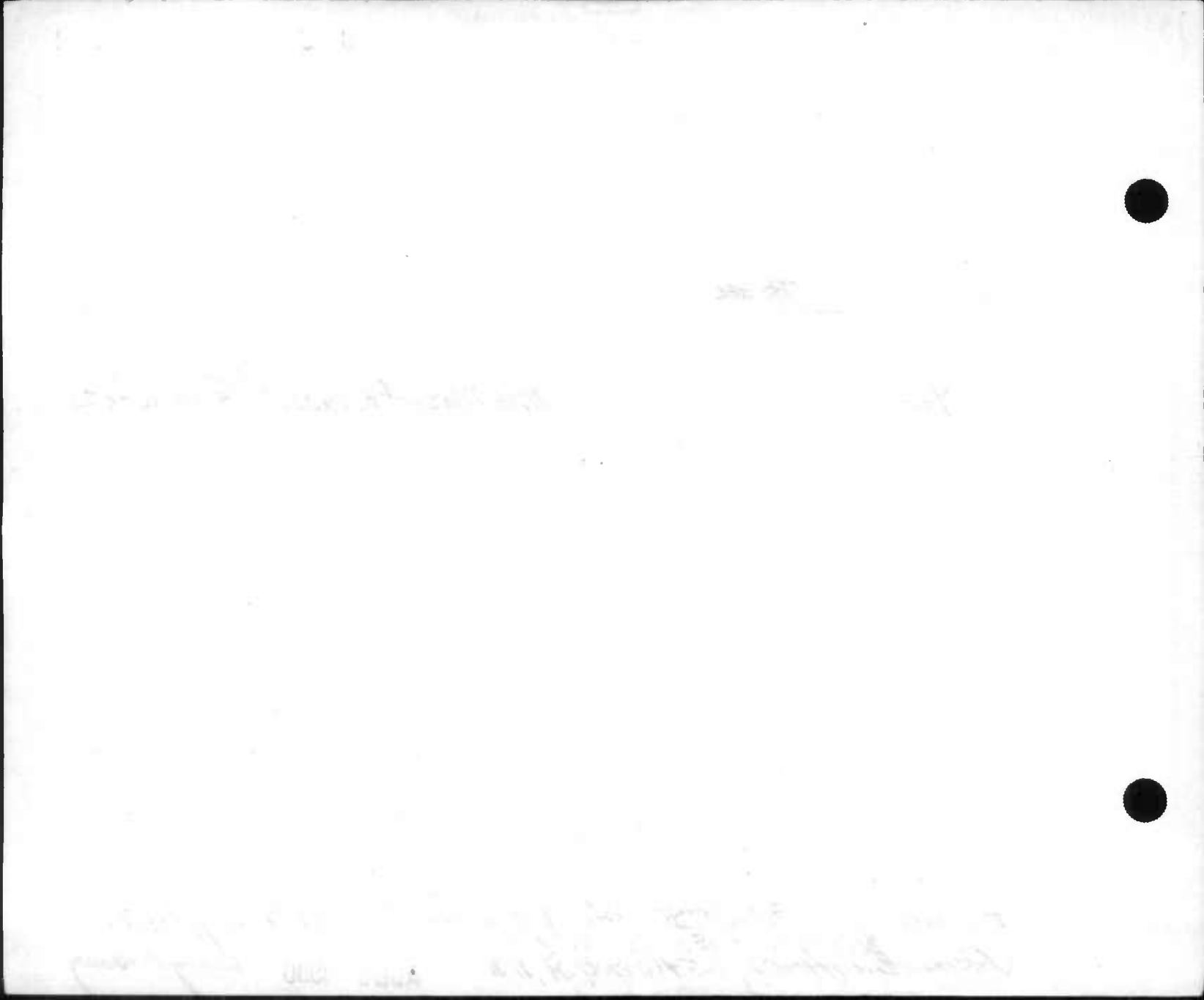
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 5 2 2	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Floyd Dixon						2a. DATE OF DEATH MONTH DAY YEAR 7-30-80			2b. HOUR 3:00 P		
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 19 17		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? Amer.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mon. T. GOMERY MD.					
10. CITY OR TOWN OF DEATH TAKOMA PK.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE md.		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN TAKOMA PK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2410 CHEROKEE ST ADELPHI			
14. FATHER'S NAME FIRST MIDDLE LAST William Floyd Dixon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA CELESTE JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Marie F. Dixon		ADDRESS (Same as above) #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 1541 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC RECTAL CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WKS 6 mos											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (we) attended the deceased from FEBRUARY 19 80 to JULY 30 19 80, that (we) last saw the deceased alive on JULY 30 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James A. Brown MD						DEGREE		22c. DATE SIGNED 7/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN MD						22e. ADDRESS 625 BELCREST RD HYATTSVILLE, MD 20782					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/2/1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION Schwab Spring, Md.				
24. FUNERAL DIRECTOR NAME Wakona Twill House, 254 Carroll St, N.W.						25a. DATE REC'D. BY REGISTRAR AUG 6 1980		25b. REGISTRAR'S SIGNATURE L. J. [Signature]			



WAIVED BY DR. BALL  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	8	5	2	3
1 - STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Luisa Guillermina Alcedan de Ruiz Remy										2a. DATE OF DEATH MONTH DAY YEAR 7-3-80				2b. HOUR 11 <sup>10</sup> PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 72 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru		7b. CITIZEN OF WHAT COUNTRY? Peru		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.										
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7701 Whittier Blvd.								
14. FATHER'S NAME FIRST MIDDLE LAST Mariano Alcedan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natividad Vallines												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Admiral Hernan Quiros Same As #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1980</u> to <u>July 3, 1980</u> , that (I) (we) lost the deceased alive on <u>July 3, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Carol L. Bender, M.D.				DEGREE M.D.				22c. DATE SIGNED 7/4/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L. Bender, M.D.				22e. ADDRESS 11125 Rockville Pike, Rockville, Md. 20852												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/9/80		23c. NAME OF CEMETERY OR CREMATORY El Angel Cemetery		23d. LOCATION CITY OR TOWN Lima		COUNTY Peru		STATE Peru						
24. FUNERAL DIRECTOR Hines Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]										

Handwritten text, possibly a signature or title, centered on the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dr. Joseph M. DiMisa			2a. DATE OF DEATH MONTH DAY YEAR July 15, 1980			2b. HOUR 7:45A <sub>M</sub>			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 2 1928		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist		12b KIND OF BUSINESS OR INDUSTRY Dentistry	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 7313 Durbin Terrace	
14 FATHER'S NAME FIRST MIDDLE LAST Francis J. DiMisa				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elvida Biacanello					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Margaret DiMisa (See Item # 13)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral infarction, severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Approx 60 hours</u> <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>July 12, 1980</u> to <u>July 15, 1980</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>July 15, 1980</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.									
22b SIGNATURE <u>Joseph A. Romeo MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED July 15, 1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo				22e ADDRESS 10401 Old Georgetown Rd. Bethesda, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1980 July 17,		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a DATE REC'D. BY REGISTRAR JUL 18 1980		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melba Ruth Dornisch			2a. DATE OF DEATH MONTH DAY YEAR July 17, 1980		2b. HOUR 12:35 <sup>a</sup> AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1940		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Upper Marlboroxx		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS 13808 Town Farm Road			
14. FATHER'S NAME FIRST MIDDLE LAST Roger O. Tilghman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Louise Hill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-5791		17. INFORMANT ADDRESS Same as Pt.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>STATUS EPILEPTICUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC Ovarian Sarcoma</u> 17 mo	
		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased <u>July 11</u> , 19 <u>80</u> , to <u>July 17</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>July 17</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.							
22b. SIGNATURE <u>Robert I. Packer</u>		DEGREE MD		22c. DATE SIGNED 7/17/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert I. Packer MD		22e. ADDRESS National Institutes Of Health Clinical Center, Bethesda, Md 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 19 July 1980		23c. NAME OF CEMETERY OR CREMATORY Washington Nat. Cem Suitland		23d. LOCATION CITY OR TOWN COUNTY STATE PG Md	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		ADDRESS Funeral Home Inc		25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

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REG. NO.

 FOR  
 1 - STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT S DUDLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 18, 1980</b>		2b. HOUR <b>2:46 PM</b>						
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 5 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arkansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Editor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Assoc. Press</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>199 Rollins Avenue #517</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Hamilton Dudley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rella Sloan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>408-10-1269</b>		17. INFORMANT <b>Sara B. Dudley</b>		ADDRESS <b>same as item 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated duodenal ulcer</b> 7146 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatoid arthritis</b> 35 years DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <b>kidney failure, pulmonary cardiac radional malfunction thrombosis</b>											
19a. DATE OF OPERATION <b>8-3-80</b>			19b. CONDITION IN WHICH OPERATION WAS PERFORMED <b>Left femoral bypass</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>none 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>none</b>					
21d. INJURY OCCURRED WHERE: <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> <b>none</b>			21e. PLACE OF INJURY (AL HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>none</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>none Bethesda Maryland</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 1972 to July 18 19 80</b> , that (I) (we) last saw the deceased alive on <b>July 18 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Allen J. O'Neill M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>July 19, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen J. O'Neill M.D.</b>						22e. ADDRESS <b>8601 Old Georgetown Rd, Bethesda MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 22, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]*

*[Handwritten notes and signatures in the lower half of the page, including a signature that appears to read 'John J. ...' and other illegible cursive text.]*

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

18527

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marvin Ehrlich		2a DATE OF DEATH MONTH DAY YEAR July 28, 1980		2b HOUR 9:45 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10/23/25	6 AGE (IN YEARS LAST BIRTHDAY) 54	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CONTACT, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b KIND OF BUSINESS OR INDUSTRY Home Improvement	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Ehrlich		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Abe		13e STREET ADDRESS 12001 Old Columbia Pike, Apt. 505	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2		17 INFORMANT ADDRESS Ms. Joy M. Ehrlich (Same as # 13)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>80</u> , to <u>7/28</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>move</u> the body after death.					
22b SIGNATURE <u>Norman Lieberman</u>		DEGREE		22c DATE SIGNED 7/29/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN LIEBERMAN		22e ADDRESS 6525 BELCREST RD Hyattsville, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 7/30/80		23c NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS	
23d LOCATION CITY OR TOWN COUNTY STATE OLNEY MONTGOMERY MD.		23e DATE REC'D. BY REGISTRAR AUG 6 1980			
24 FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.					

Location

25/10/12

Geographical Context

Notes from Field

Observations

Notes from

Notes

Notes

Notes

Notes from 25/10/12

Notes

Notes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8018528	
1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Hiram Shunk Evans</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7-24-80</b>		2b. HOUR <b>840 A.M.</b>				
3 SEX <b>male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD					
10 CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>720 Gist Avenue</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Evans</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriett Shunk</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>216-44-4511</b>		17. INFORMANT ADDRESS <b>Timothy Lovelace 6 Winding Wave Court Wheaton, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <b>SEIZURE</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>METASTATIC CARCINOMA OF COLON</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>IMMEDIATE</b> <b>1 YEAR</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>N/A</b>											
19a. DATE OF OPERATION <b>7-8-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC OUTLET OBSTRUCTION</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 30</b> , 19 <b>80</b> , to <b>JULY 24</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7-21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stanley M. Knoll, MD</b>										22c. DATE SIGNED <b>7-24-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY M. KNOLL, MD</b>										22e. ADDRESS <b>1145 19th St NW WASH. DC 20036</b>	
23a. BURIAL, CREMATION, REMOVAL (SPEC) <b>Removal</b>		23b. DATE <b>7-24-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Univ Medical School</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wash DC</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Metropolitan F.S. Alexandria, VA</b>										25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 2 9  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret C Evans			2a. DATE OF DEATH MONTH DAY YEAR 7-20-80		2b. HOUR 1 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 24 10		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrators		12b. KIND OF BUSINESS OR INDUSTRY School Bd. Mont. Cty.
13a. STATE MD			13b. COUNTY Mont. Co.	13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Williams Cummins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Bell Jarvis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-3155		
17. INFORMANT son Edward R. Evans			ADDRESS 518 Riverside Drive Pasadena, Maryland		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic vasc. disease per. sys.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days (known for)
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William F. Collins, Jr. MD				22c. DATE SIGNED 7/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM F. COLLINS, JR.				22e. ADDRESS 10301 Georgia Ave. SS, MD 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jul. 23, 1980	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Bk. Geo. Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR JUL 21 1980	
500 University Blvd., W. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

Enclosed for the New York Office are two copies of a letterhead memorandum dated and captioned as above. The letterhead memorandum was prepared by the New York Office on [Illegible] and is being furnished to you for your information and guidance.

The letterhead memorandum contains information regarding the activities of [Illegible] and is being furnished to you for your information and guidance. The letterhead memorandum is being furnished to you for your information and guidance.

The letterhead memorandum contains information regarding the activities of [Illegible] and is being furnished to you for your information and guidance. The letterhead memorandum is being furnished to you for your information and guidance.

The letterhead memorandum contains information regarding the activities of [Illegible] and is being furnished to you for your information and guidance. The letterhead memorandum is being furnished to you for your information and guidance.

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 5 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL G. FARRAH</b>			2a. DATE OF DEATH MONTH <b>JULY</b> DAY <b>11</b> YEAR <b>80</b>		2b. HOUR <b>8:10 P.M.</b>
3 SEX <b>MALE</b>	4 RACE <b>CAUCASIAN</b>	5 DATE OF BIRTH MONTH <b>SEPT</b> DAY <b>15</b> YEAR <b>1899</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LEBANON</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>MONTGOMERY</b> MD.		
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER-OPERATOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b> COUNTY <b>MONTGOMERY</b> CITY OR TOWN <b>SILVER SPRING</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS <b>10604 MALONE ST.</b>	
14. FATHER'S NAME FIRST <b>SHEEDED</b> MIDDLE <b></b> LAST <b>FARRAH</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARIEN</b> MIDDLE <b></b> LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-01-5152</b>	17 INFORMANT ADDRESS <b>EFFIE FARRAH SAME AS 13 E</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **VENTRICULAR ARYTHMIA****15 MIN**4149  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **CORONARY ARTERY DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **HYPERTENSION - ATHEROSCLEROSIS**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

**NA**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>NA</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N.A.</b> 19 <b></b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N.A.</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>	21f. LOCATION STREET <b>N.A.</b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/6/80</b> , 19 <b></b> , to <b>7/11</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Jeffrey W. Collins</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>7/12/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEFFREY W. COLLINS M.D.</b>		22e. ADDRESS <b>7221 HIDDEN CREEK RD, BETHESDA</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>7/14/80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b> COUNTY <b>MONT</b> STATE <b>MD.</b>
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>	25b. REGISTRAR'S SIGNATURE <b>Jeffrey W. Collins</b>

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18531

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLARD CHRISTY FIGARD		2a. DATE OF DEATH MONTH DAY YEAR 7 12 80		2b. HOUR 3 05 P.M.	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCT. 15 1917		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONCRETE		12b. KIND OF BUSINESS OR INDUSTRY CONST.
13a. STATE MD.		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BURTONSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES C FIGARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 170-12-6707		17. INFORMANT ADDRESS ELIZABETH S. FIGARD SAME AS 13F.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest 1622 DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Carcinoma of hilum 4 months DUE TO, OR AS A CONSEQUENCE OF (c) Collapsing Lung - COPD 4 months PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 18 19 80 to July 12 19 80, that (I) (we) last saw the deceased alive on July 12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Adrian Selfa M.D.		DEGREE M.D.		22c. DATE SIGNED July 12, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADRIAN SELFA M.D.		22e. ADDRESS 2100 CARROLL AVE TAKOMA PARK, MD 20012			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE July 14, 1980	23c. NAME OF CEMETERY OR CREMATORY 471107		23d. LOCATION CITY OR TOWN COUNTY STATE BURTONSVILLE MONTGOMERY MD.	
24. FUNERAL DIRECTOR NAME FLECK LAUREL FUNERAL HOME		24b. ADDRESS 7601 SANDY SPRING RD LAUREL, MD 20810		25. DATE REC'D. BY REGISTRAR JUL 14 1980	
				25b. REGISTRAR'S SIGNATURE Rafaela K. K. K.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DAVID John FITZGIBBON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 20 80</b>		2b. HOUR M <b>930</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18 1902</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dentist</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>D.C.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Fitzgibbon</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Donovan</b>		13d. STREET ADDRESS <b>Apt. 419 3003 Van Ness Street, N.W.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17 INFORMANT <b>Sister Catherine J. Goselin</b> ADDRESS <b>6 Leonard Street Athol, Mass. 01331</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Acute Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>4 weeks</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, Heart Disease, Prolonged Perfect Ulcers</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>1980</b> , that (I) (we) last saw the deceased alive on <b>1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William Henry Kellay</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-21-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Henry Kellay</b>		22e. ADDRESS <b>8218 Wisconsin Ave Bethesda Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 23, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gethsemane Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Athol Worcester Mass.</b>		24. BURIAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>John H. Brady</b>					

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18533

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Renee Kim Fletcher		July 2, 1980		7:49AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	January 22, 1963	17	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Clinical Center, NIH, Beth, Md		Student		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Allegany	Pittsboro	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Route #1 Box 32	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Philip Francis Fletcher		Norma Kathleen Renn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mr. Philip Fletcher (father) Same as Patient	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY					12 HOURS
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK					
DUE TO, OR AS A CONSEQUENCE OF					
(b) S/P OPEN-HEART SURGERY					24 HOURS
DUE TO, OR AS A CONSEQUENCE OF CONGENITAL HEART DISEASE -					
(c) DOUBLE OUTLET RIGHT VENTRICLE					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
7/1/80		DOUBLE OUTLET RIGHT VENTRICLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from June 29, 1980, to July 2, 1980, that (we) last saw the deceased alive on July 2, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Karl J. Karlson, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		7/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
KARL J. KARLSON, MD		National Institutes of Health Clinical Center, Bethesda, Md 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-6-80		Price Mem. Wesleyan	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
		Little Orleans		Allegany Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Richard J. Grove Hancock MD		JUL 10 1980			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, mostly illegible text covering the main body of the page, possibly a ledger or report.]*



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80	18534
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sam Fligel</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>07 13 - 80</i>					2b. HOUR <i>10:16 AM</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 23 06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS <i>1 15</i>		IF UNDER 24 HRS HOURS MIN <i>15</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Nebraska</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Expediter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>3M Co.</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>7401 Westlake Terrace</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Fligel</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Morowitz</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>322-05-8461A</i>		17. INFORMANT ADDRESS <i>Mattie K. Fligel; 7401 Westlake Terr, Beth, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<div> <div>410 -</div> <div>           DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Fibrillation</i>            DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i> </div> </div>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.) <i>Severe Myocardial and Coronary Artery Disease</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7 13 19 80</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 19 80</i> to <i>7/13 19 80</i> , that (I) (we) last saw the deceased alive on <i>7/13 19 80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Leonard A. Wisneski, MD</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/13/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Leonard A. Wisneski, MD</i>				22e. ADDRESS <i>6410 Rockledge Dr. #308 Bethesda, Md. 20834</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>July 15, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westlawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Norwood Park, Illinois</i>			
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels;</i>				ADDRESS <i>1170 Rockville Pike</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 17 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Richard McCreedy</i>			

1881-08

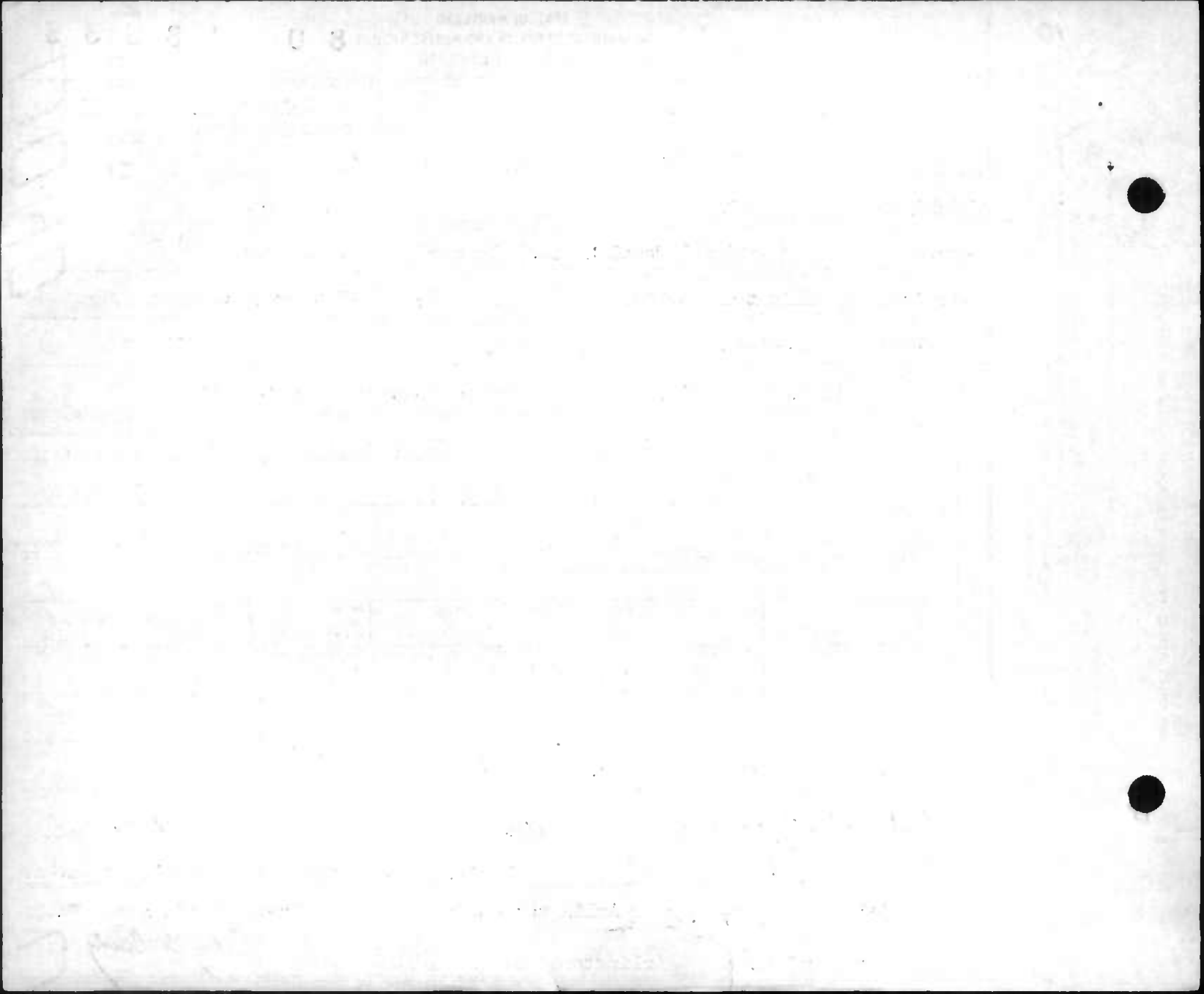
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 3 5  
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard E. FORMAN		2a. DATE OF DEATH MONTH DAY YEAR July 22 1980	
3. SEX Male		2b. HOUR 11:00P <sup>M</sup>	
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12 1918	
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia		13b. COUNTY Arlington	
13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 3708 North Vermont			
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Jefferson Forman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Lillie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-68	
17. INFORMANT Margaret Forman		ADDRESS See item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Prostate Cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 wks</u> <u>5 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>1</u> (this hospital) attended the deceased from <u>July 15</u> , 19 <u>80</u> , to <u>July 22</u> , 19 <u>80</u> , that <u>1</u> (we) lost <u>saw</u> the deceased alive on <u>July 22</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>1</u> (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Richard H. Lewis</u>		DEGREE <u>MD</u>	
22c. DATE SIGNED <u>24 July 80</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard H Lewis MD</u>		22e. ADDRESS <u>National Naval Medical Center Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>July 28, 1980</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Arlington Va.</u>	
24. FUNERAL DIRECTOR NAME <u>Murphy Funeral Home</u>		ADDRESS <u>Arlington, Va.</u>	
25a. DATE REC'D. BY REGISTRAR <u>JUL 29 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 3 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna L. FRANK</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-15-80</i>			2b. HOUR <i>11:30 P.M.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>FEB 16, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>GREECE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>	
13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>LUKAS</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HELEN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>NONE</i>		17. INFORMANT <i>SON</i> <i>WILLIAM S. FRANK</i>			
				ADDRESS <i>10703 LOCKRIDGE DRIVE SILVER SPRING, MD.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

*4331*  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) *Cerebral Vascular accident*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Thrombosis & dist. Cerebral artery*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>65</i> , to <i>July 15</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>July 15</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) see the body after death.							
22b. SIGNATURE <i>Edward Richards</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7-16-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWARD RICHARDS</i>				22e. ADDRESS <i>10301 GEORGIA AVE., SILVER SPRING, MD.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/19/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON, D. C.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 17 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McNeely</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

80 1-3-30

W.A.

WHITE FEB 10, 1900

HOUSE

HOLY CROSS HOSPITAL

MONTGOMERY SILVER SPRING

18004 CHIFFIELD ROAD

HELEN

WILLIAM E. FRANK

SON

STREET

STREET

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEENE D. FRANKLIN			2a. DATE OF DEATH MONTH DAY YEAR 7-24-80				2b. HOUR 7:15 P.M.	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 20 88	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KNOXVILLE TENN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					

10. CITY OR TOWN OF DEATH GAITHERSBURG			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERMAN WILSON HEALTH CARE CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 10432 ROCKVILLE PIKE #201									

14. FATHER'S NAME FIRST MIDDLE LAST JOHN ALAN D. PHAM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah McKEE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-84-6866		
17. INFORMANT Records of Health Care Center			ADDRESS 301 Russell Ave. Gaithersburg, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Abnormal heart function DUE TO, OR AS A CONSEQUENCE OF (c) Stroke - CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3d	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 23 May 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE PAUL NOONE				22c. DATE SIGNED 7/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 50 WEST EDMONSTON DR. 20852				22f. MEDICAL STAFF PHYSICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7/25/80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
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24. FUNERAL DIRECTOR NAME GARTNER SANDISON F.H. Gaithersburg, Md.		25. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 104

المجلس الأعلى



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 3 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura Anne French			2a. DATE OF DEATH MONTH DAY YEAR 7 8 80		2b. HOUR 12 <sup>34</sup> M	
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 7 7 80		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS		7 UNDER 1 YEAR MONTHS DAYS 16 26
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William G. French			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anne Bennett			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. None		17 INFORMANT FATHER ADDRESS 9433 Muirkirk Road William G. French Laurel, Md. 20811		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 7581 DUE TO, OR AS A CONSEQUENCE OF (b) Asphyxia 13 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 7/7 19 80 to 7/8 19 80, that (I) (we) lost saw the deceased alive on 7/7 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stanley H. Steingberg, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY H. STEINGBERG, M.D.				22e. ADDRESS 831 UNIVERSITY BLVD. E. SILVER SPRING, MD. 20903		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/12/80	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home				25. DATE REC'D. BY REGISTRAR JUL 14 1980		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Order reflecting features  
January 13

7/7/20

James H. Greenleaf, and  
James H. Greenleaf, and

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

8 0 1 8 5 3 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Klara</i>		MIDDLE		LAST <i>Frenkel</i>		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH <i>7</i>		DAY <i>13</i>		YEAR <i>1980</i>		2b. HOUR <i>1:59</i>		MIN.			
3. SEX <i>Fe</i>		4. RACE <i>CAUC</i>		5. DATE OF BIRTH MONTH <i>9</i> DAY <i>20</i> YEAR <i>90</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH <i>7</i>		DAY <i>13</i>		YEAR <i>1980</i>		2d. HOUR <i>1:59</i>		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.											
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE <i>MD</i>				13b. COUNTY <i>MONT.</i>				13c. CITY OR TOWN <i>CHEVY CHASE</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>BETHESDA RETIREMENT CENTER</i>							
14. FATHER'S NAME FIRST <i>Julius</i> MIDDLE <i>Prinz</i> LAST <i>Prinz</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Karoline</i> MIDDLE <i>Noerdlinger</i> LAST <i>Noerdlinger</i>						16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>											
16a. SOCIAL SECURITY NO. <i>064-18-7715</i>						17. INFORMANT ADDRESS <i>George Frenkel, 10023 Kensington Pkwy. Kensington, Md.</i>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBROVASCULAR ACCIDENT</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CEREBRAL ARTERIOSCLEROSIS</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE</i> <i>5 DAYS</i> <i>15-20 YRS</i>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>DIABETES MELLITUS. FRACTURED RIGHT HUMERUS + Rt Femur</i>																							
19a. DATE OF OPERATION <i>7-7-80</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>FRACTURED Rt HIP Rt HUMERUS</i>												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10 P.M. 7 1980</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>FELL &amp; WALKER IN NURSING HOME</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Nursing Home</i>				21f. LOCATION STREET <i>Bethesda Ret. Cent.</i> CITY OR TOWN <i>Chevy Chase</i> COUNTY <i>Mont</i> STATE <i>MD</i>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>F.C. Mayke</i>				TITLE (SPECIFY) <i>Deputy</i>				M.D. <i>Deputy</i>				MEDICAL EXAMINER <i>Deputy</i>				DATE SIGNED <i>7/13/80</i>							
EXAMINER'S NAME (TYPE OR PRINT) <i>F.C. MAYKE</i>				ADDRESS <i>8200 Wisconsin Ave Bethesda MD 20814</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jul. 15, 1980</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Beth Israel</i>				23d. LOCATION CITY OR TOWN <i>Woodbridge</i> COUNTY <i>N. J.</i> STATE <i>N. J.</i>											
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Inc.</i> ADDRESS <i>1170 Rockville Pk.</i>										25a. DATE REC'D. BY REGISTRAR <i>JUL 17 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>									

801828

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 8 5 4 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE</b>		FIRST <b>Katherine</b> MIDDLE <b>W.</b> LAST <b>Freshman</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 24 80</b>		2b. HOUR <b>1:30 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 18 1886</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rhode Island</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10 CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Retirement &amp; Nursing Cen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridgette Sullivan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-84-1183</b>		17 INFORMANT ADDRESS <b>C. Arnold Freshman, Son. Same as item 13.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coccaroma of colon with metaplasia</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>							
19a. DATE OF OPERATION <b>15 Feb 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Colostomy for carcinoma of colon</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 11 1975</b> to <b>July 24 1980</b> , that (I) (we) last saw the deceased alive on <b>July 5 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harry A Horstman</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>July 24 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harry A Horstman, M.D.</b>		22e. ADDRESS <b>5454 Wisc. Ave., N.W. Wash., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/26/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>	
24 FUNERAL DIRECTOR'S NAME <b>Joseph Gawler's Sons, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1980</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. McCreedy</b>	
24 ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>							



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please mail to the funeral director or retaining physician. The law requires that the death certificate be executed within 24 hours after death. Please mail to the funeral director or retaining physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 above, any injury or other traumatic event, the medical examiner must be not just a physician.

0804

OHHM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 5 4 1 REG NO				
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) <b>DUANE Alfred Frew</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 10 80</b>			2b. HOUR <b>3<sup>30</sup> A.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 13 1922</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>							
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Village Montgomery</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Frew</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Tolf</b>					16. STREET ADDRESS <b>10102 Little Pond Place</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>					16b. SOCIAL SECURITY NO. <b>185-14-3641</b>		17 INFORMANT (Wife) <b>Stella Frew</b>		ADDRESS <b>Gaithersburg, MD 10102 Little Pond Pl.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Lung with</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 MGS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from <b>7/7/80</b> , 19 <b>80</b> , to <b>7/10/80</b> , 19 <b>80</b> , that (I) (the hospital) last saw the deceased alive on <b>7/7/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE <b>Lawrence J. Thomas MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/10/80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Lawrence J. Thomas</b>						22e. ADDRESS <b>11801 Rockville Pike Rockville, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 14, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery Monessen</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Monessen Pennsylvania</b>				
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 15 1980</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

1408108  
7/10/50

Dr. Ball notified & releases body  
to me for issuance of death  
certificate

J. Leana 24.0



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

160

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - STATE REGISTRAR					8 0 1 8 5 4 2					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST <u>Donald</u> MIDDLE <u>Fulkerson</u> LAST <u>FULKERSON</u>					MONTH <u>JULY</u> DAY <u>8</u> YEAR <u>80</u> HOUR <u>1:48</u> AM					
3. SEX <u>Male</u>		4. RACE <u>CAUC - White</u>		5. DATE OF BIRTH MONTH <u>April</u> DAY <u>5</u> YEAR <u>1908</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS		7b. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.				
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Special Agent</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>				
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Pr. Geo.</u>		13c. CITY OR TOWN <u>Adelphi</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>8102 New Riggs Road</u> 20783	
14. FATHER'S NAME FIRST <u>Sterling</u> MIDDLE <u>Fulkerson</u> LAST <u>Fulkerson</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Emma</u> MIDDLE <u>Dunsdan</u> LAST <u>Dunsdan</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>W.W. II.</u>		17. INFORMANT (Wife) <u>Mary B. Fulkerson</u>		ADDRESS <u>Same As #13</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>ARTEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>CONGESTIVE HEART FAILURE</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINS. 20 MINS.</u> <u>MOS. 70 YRS.</u> <u>MOS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC RENAL DISEASE</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 28</u> , 19 <u>80</u> , to <u>JULY 8</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>JULY 8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERT A. GROLLMAN, MD</u>					22c. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>			22d. DATE SIGNED <u>7/8/80</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>July 11, 80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Mont. Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u> ADDRESS <u>11800 N.H. Ave.</u>					25a. DATE REC'D. BY REGISTRAR <u>JUL 10 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 5 4 3

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST George		MIDDLE Powers		LAST Fulton		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7/9 19 80		2b. HOUR M 11:25 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 7/9 19 80		7d. HOUR P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 611 Lambertson Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXEC DIRECTOR NATL INST OF DRY CLEANING		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 611 Lambertson Drive					
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE ROEDEL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 214-03-8497		17. INFORMANT JACQUELINE FULTON		ADDRESS SAME AS 13		WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 7/10/80							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/12/80		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR JUL 11 1980		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018544			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	
RAY			R.			FUNKHOUSER			7			5 30 P.M.	
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR	
Male			White			MONTH DAY YEAR			69 YRS.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10b. KIND OF BUSINESS OR INDUSTRY	
Virginia			USA						Montgomery MD.			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS	
Silver Spring			Holy Cross			Manager, U.S. Gov't. Printing			Card Catalog Division			14223-Georgia Ave.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
Maryland			Montgomery			Sil.Spg.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14223-Georgia Ave.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS	
Charles Franklin Funkhouser			Ethel Vherne Funkhouser			Yes			W.W.11			14223-Georgia Ave. Sil.Spg., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) Cerebral Vascular Accident									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Retrospective Carcinoma										
			DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the lung										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
						P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital attended the deceased from July 5, 1974, to July 5, 1980, that (I) last saw the deceased alive on July 5, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
			Robert Kramer M D						7/5/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY	
			8630 FENTON ST. SIL. SPG. MD.			Cremation			July 7, 80			Fort Lincoln Crematory Brentwood, P.G. Md.	
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			26a. DATE REC'D. BY REGISTRAR			26b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi F.H. Inc. Sil.Spg.Md.			11800-N.H.Ave.						JUL 9 1980				

[illegible]

97 17 1998

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 30 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 5 4 5

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Ronald		MIDDLE Glenn		LAST Garrison		2a. DATE KNOWN OF DEATH		MONTH 7		DAY 25		YEAR 1980		2b. HOUR 9:10P	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 11, 1959		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 7		DAY 25		YEAR 1980		2d. HOUR 9:10P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3604 Manor Wood Drive		14. FATHER'S NAME FIRST MIDDLE LAST Ronald E. Garrison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jo Anne Horton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 76 4037		17. INFORMANT ADDRESS Jo Anne Garrison, Same as #13 (Mother)	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:50PM 7/25 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) side of passing vehicle driver of moped/fixed object/ejected into															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE South Hampton Dr & New Hampshire Aves. Mont Co MD															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>H R Guard</i>		TITLE (SPECIFY) Assistant		M.D.		MEDICAL EXAMINER		DATE SIGNED 7/26/80									
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto. MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/30/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.													
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, PA		ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 29 1980		25b. REGISTRAR'S SIGNATURE <i>Robert K. Brady</i>													

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 4 6

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BETTY GELLER</b>		2. DATE OF DEATH MONTH DAY YEAR <b>7/31/80</b>		2b. HOUR <b>9:00 A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 15 88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY NURSING HOME</b>		12a. USUAL OCCUPATION/ (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC HERING</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLLY KOTLER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>131-38-7341</b>	
17. INFORMANT ADDRESS <b>BEBE WOLK, same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/2 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8630 FENTON ST. SILVER SPRING, MD 20910</b>			
22a. I certify that (1) (this hospital) attended the deceased from <b>7/26 19 80</b> to <b>7/31 19 80</b> , that (1) (was) lost view of the deceased alive on <b>7/26 19 80</b> , and that (1) (my) opinion death occurred on the date and hour and from the causes stated above (or was) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ralph E. Seligmann</b>		DEGREE <b>MD</b>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/31/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RALPH E. SELIGMANN</b>		22e. ADDRESS <b>8630 FENTON ST. SILVER SPRING, MD 20910</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/3/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELMTON, LONG ISLAND, NEW YORK</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>RONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>				25. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		26. REGISTRAR'S SIGNATURE <b>Helen Halpern</b>	

0 8 0 0 0 0

ONE HUNDRED

THIRTY EIGHT DOLLARS

PAID

PAID

PAID

PAID

JOHN WILK, JR. & CO.

191-20-1391

*Handwritten signature*

PAID TO ORDER OF J. C.

PAID

PAID TO ORDER OF J. C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18547

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HORACE W GERMANN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7/21/80</b>		2b. HOUR AM PM <b>5:35 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 15 '04</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>76</b>		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>		
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PR. GEORGE</b>		13c. CITY OR TOWN <b>LANHAM</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE GERMANN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY GITTINGS</b>		16. STREET ADDRESS <b>9406-3rd PLACE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-03-7711</b>		17. INFORMANT ADDRESS <b>MRS MARY ANN COX SILVER SPR. Md</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>2387</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Severe pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Mycoplasma pneumoniae Syndrome</b> APPROXIMATE TIME BETWEEN ONSET AND DEATH <b>6/12/80</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GI bleeding CAD &amp; Angina</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/14</b> , 19 <b>80</b> , to <b>7/20</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Paul Andrews MD</b>		22c. DATE SIGNED <b>7/21/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/24/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND, PR. GEORGE Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur Walter</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>Washington D.C. 20002</b>	

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE HOUSE OF REPRESENTATIVES

IN RESPONSE TO A RESOLUTION PASSED BY THE HOUSE

APRIL 1880  
WASHINGTON  
GOVERNMENT PRINTING OFFICE  
1880

THE HOUSE OF REPRESENTATIVES  
COMMISSIONER OF THE GENERAL LAND OFFICE  
WASHINGTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 4 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ETTA C. GILLMAN		2a. DATE OF DEATH MONTH DAY YEAR 7-14-80		2b. HOUR 4 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Beth. Retirement & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clinical Psychologist		12b. KIND OF BUSINESS OR INDUSTRY School System
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4909 Essex Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST Abraham Cohen		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Gapowitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 084-32-3006 A		17 INFORMANT ADDRESS Dr. Robert D. Gillman-Son- Same as Item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4148 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>myocardial infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 yrs 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Cardiovascular arteriosclerosis, polycythemia vera</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> 19 <u>80</u> to <u>7/14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert D. Gillman MD</u>		DEGREE MD		22c. DATE SIGNED 7/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT D. GILLMAN		22e. ADDRESS 4909 ESSEX AVE CHEVY CHASE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE 7/15/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION CITY OR TOWN Suitland, Md.		COUNTY		STATE	
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> 25130 Wisc. Ave. N.W. Wash., D.C. 20016		25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE <u>Robert D. Gillman</u>	

84631-08

RECEIVED

3

1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

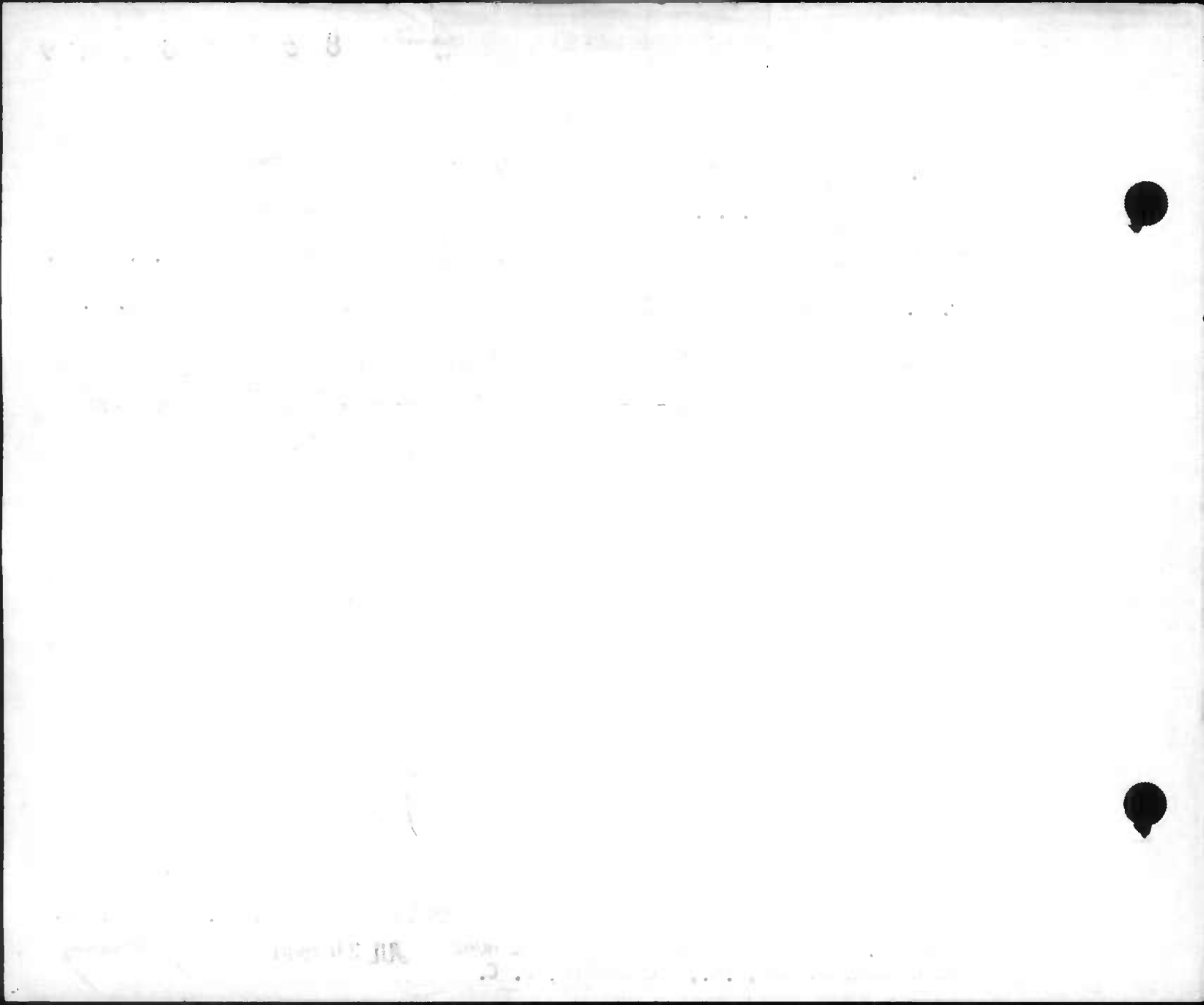
BP \_\_\_\_\_  
DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 4 9

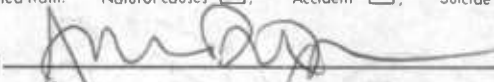
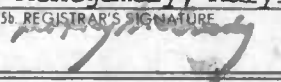
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CELIA NAOMI GINSBURG			2a. DATE OF DEATH MONTH DAY YEAR JULY 24 1980			2b. HOUR 11:4-M					
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JUNE 6, 1886		6 AGE (IN YEARS LAST BIRTHDAY) 94		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.					
13a. STATE D. C.			13b. COUNTY none		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6320 14th STREET, N. W.		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM ABRAMSON				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unascertainable) (unascertainable)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-30-5651			17 INFORMANT THEODORE GILBERT, BALTIMORE, MARYLAND			ADDRESS 2410 LIGHTFOOT DRIVE,		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLEURAL EFFUSION - RESPIRATORY FAILURE 2 MONTHS 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) METASTATIC CARCINOMA FROM BREAST DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) ARTERIOSCLEROTIC + HYPERTENSIVE HEART DISEASE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 1953, to JULY 24 1980, that (I) (we) last saw the deceased alive on JULY 24 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Krichmar						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED JULY 24 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. KRICHMAR						22e. ADDRESS 7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/28/1980		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY			23d. LOCATION ADELPHI, PR. GEORGES, MD.			
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.						25a. DATE RECEIVED BY REGISTRAR JUL 30 1980		25b. REGISTRAR'S SIGNATURE			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL S. GLASS</b>											
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 24, 1944</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>35</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7-18-80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>		12c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 18 80</b>		2b. HOUR <b>8:45 P</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Tridelphia Lake</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Computer Syst.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10309 Armory Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward M. Glass</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Patricia Marie Kayes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>301-38-5387</b>		17. INFORMANT ADDRESS <b>Kensington, Md. Marion M. Glass; 10309 Armory Avenue</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>954- Drowning</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-18-80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject found in water.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Tridelphia Lake Montgomery Md.</b>					
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>7-19-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 21, '80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Montgomery, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18551

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>YETTA</i> MIDDLE <i>BETTY</i> LAST <i>GOLDBERG</i>		2a. DATE OF DEATH MONTH <i>7</i> DAY <i>28</i> YEAR <i>80</i>		2b. HOUR <i>9:15</i> P.M.	
3 SEX <i>Female</i>	4 RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH <i>AUGUST</i> DAY <i>25</i> YEAR <i>1890</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>LATVIA</i>	7b CITIZEN OF WHAT COUNTRY? <i>none</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DMORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MARYLAND</i> COUNTY <i>MONTGOMERY</i> CITY OR TOWN <i>SILVER SPRING</i>		13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS <i>11700 OLD COLUMBIA PIKE</i>	

14. FATHER'S NAME FIRST <i>ABRAHAM</i> MIDDLE <i>LEVINSON</i>		15. MOTHER'S MAIDEN NAME FIRST <i>CECELIA</i> MIDDLE <i>HAYMAN</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO <i>220-54-1121</i>	
17 INFORMANT <i>MICHAEL M. GOLDBERG,</i>		ADDRESS <i>1103 DUNOON ROAD, SILVER SPRING, MD.</i>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>pulmonary failure</i> DUE TO, OR AS A CONSEQUENCE OF (b): <i>arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c): <i>hypertension</i>		APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>hypertension</i>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>80</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/6/80</i> to <i>7/28</i> 19 <i>80</i> and that (I) (we) last saw the deceased alive on <i>7/28</i> 19 <i>80</i> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Lewis H. Dennis</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/9/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LEWIS H. DENNIS, M. D.</i>		22e. ADDRESS <i>831 UNIVERSITY BOULEVARD, EAST, SILVER SPRING, MARYLAND</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/30/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OHED SHOLOM TALUD TORAH CONGREGATION CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>WASHINGTON</i> COUNTY <i>D. C.</i> STATE <i>D. C.</i>	
24 FUNERAL DIRECTOR <i>STERN HEBREW MEMORIAL FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 6 1980</i>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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UNITED STATES DEPARTMENT OF JUSTICE

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11736 OLD COLUMBIA FIVE

SILVER SPRING

MONTGOMERY

MARYLAND

HAYMAN

CECELIA

LATCHSON

ALABAMA

11736 OLD COLUMBIA FIVE

SILVER SPRING

MONTGOMERY

MARYLAND

NO

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MARYLAND

11736 OLD COLUMBIA FIVE

WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2900

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 5 2  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE GOLDMAN GERTRUDE GOLDMAN		2a. DATE OF DEATH MONTH DAY YEAR 7/9/80 240 P.M.	
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JULY 27, 1894	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10 CITY OR TOWN OF DEATH CHEVY CHASE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA NURSING & RETIREMENT CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING
14 FATHER'S NAME FIRST MIDDLE LAST NATHAN BLENDMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FAIGARUCHEL KOTZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-34-7053D	
17 INFORMANT MRS. FRANCES G. WASSER		ADDRESS 5120 33rd STREET, N.W. WASHINGTON, D.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 4370 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED CEREBRAL ATHEROSCLEROSIS SEVERAL YEARS SEVERAL YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-36 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CARCINOMA OF COLON - ASHD - METASTATIC LUNG DISEASE			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/9 to 7/9 1980, that (I) (we) lost saw the deceased alive on 7/9 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Lawrence D. Manuws MD	DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/9/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE D. MANUWS	22e. ADDRESS 1111 SPRING ST., S.E. W 20910		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/13/1980	23c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CONGREGATION CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.			
DATE REC'D. BY REGISTRAR JUL 16 1980		REGISTRAR'S SIGNATURE [Signature]	

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

JULY 17, 1934

MEMPHIS

U.S.A.

UNITED STATES

WILLIAM CHASE

WILLIAM CHASE

1001 SOUTH STREET

WILLIAM CHASE

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NOTE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 0 1 8 5 5 3 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) FIRST Cecil MIDDLE J LAST Goodman <i>Cecil J Goodman</i>					2a. DATE OF DEATH MONTH DAY YEAR 7 / 21 / 80				
3. SEX M male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7b. HOUR 5:48 M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) service Representative		12b. KIND OF BUSINESS OR INDUSTRY MACHINES	
13a. STATE Md.		13b. COUNTY Queen Anne		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Alleganey Ave. Box #702	
14. FATHER'S NAME FIRST Jess MIDDLE C. LAST Goodman		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Madge LAST Caldwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) WW #2					
16b. SOCIAL SECURITY NO 431-01-3273		17. INFORMANT ADDRESS Mr. Jeffrey Scott Goodman, Box #702 Stevensville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Shock</i> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Disseminated intravascular coagulation 24 hrs.</i> (c) <i>Widely metastatic carcinoma Prostate 10 mo.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Pneumonitis - Diffuse atherosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/18</i> 19 <i>80</i> to <i>7/21</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/20</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. P. DeLaney</i>		DEGREE ATTENDING PHYSICIAN		MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H323 Harvard St, Silver Spring, Md 20906		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-24-80		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION CITY OR TOWN Easton		23e. COUNTY STATE Talbot Md.	
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Fun. Home, Chester, Md. 21619		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>			



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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 1 8 5 5 4

1 - FOR  
STATE  
REGISTRAR

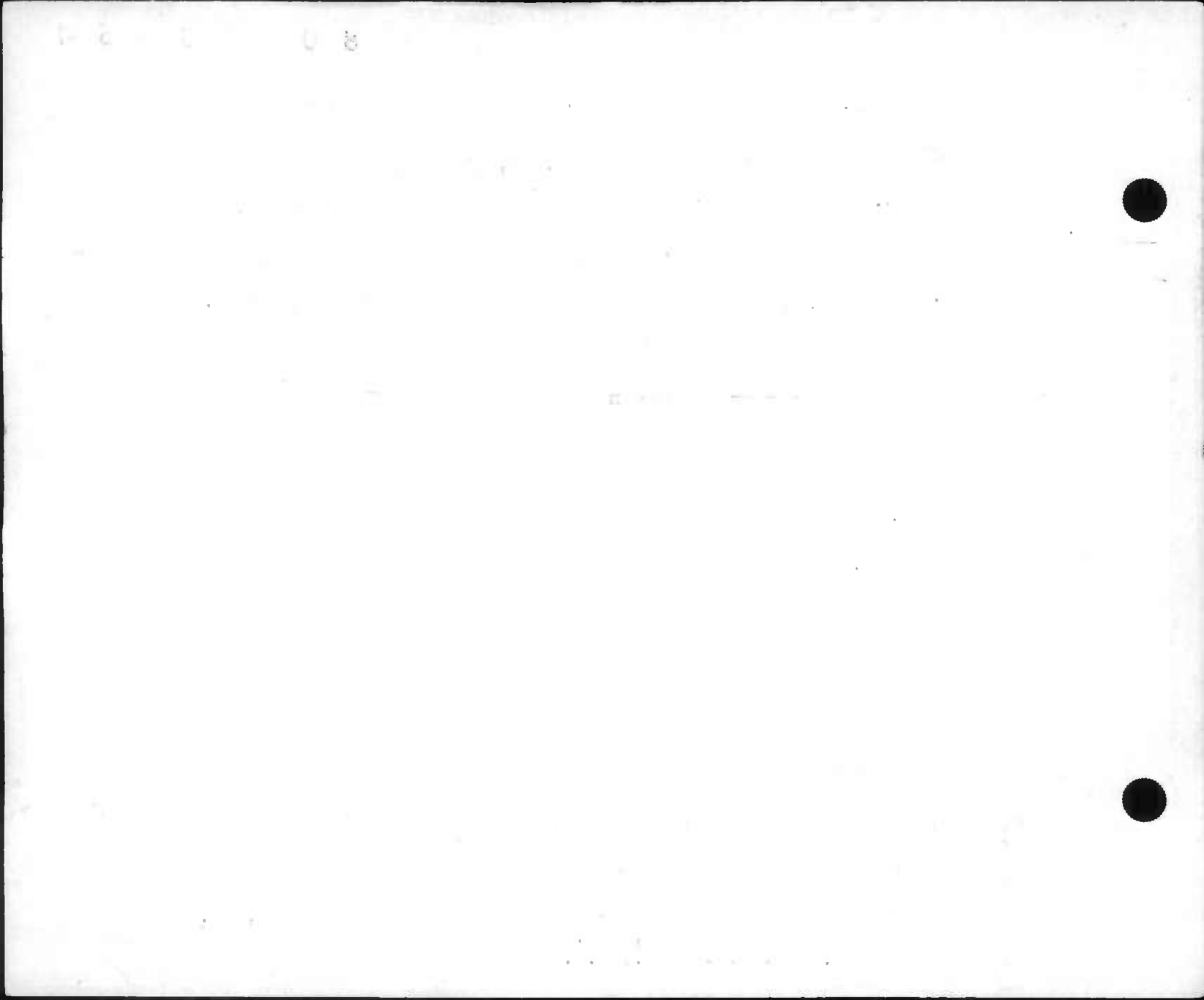
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY GRADY GORE			2a DATE OF DEATH MONTH DAY YEAR 7/3/80		2b HOUR 11:15 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL INC		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b KIND OF BUSINESS OR INDUSTRY Lawyer	
13a STATE Md.	13b COUNTY Montgomery	13c CITY OR TOWN POTOMAC	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11300 River Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Lemuel GRADY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Unknown)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17 INFORMANT ADDRESS James Gore-Son-Same as Item # 13		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6-29 19 80, to 7-3 19 80, that (we) last saw the deceased alive on 7-3 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Thomas G. Sundersen, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 7-4-80
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SUNDENSEN, MD		22e ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, Md 20851	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 7/5/80	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum	23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016		25 DATE REC'D BY REGISTRAR JUL 8 1980	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Louis</i>		MIDDLE <i>Corin</i>		LAST <i>Gorin</i>		2a. DATE KNOWN OF DEATH MONTH <i>7</i> DAY <i>27</i> YEAR <i>1980</i>		2b. DATE ESTIMATED OF DEATH MONTH <i>7</i> DAY <i>27</i> YEAR <i>1980</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>7</i> DAY <i>24</i> YEAR <i>1931</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>49</i> YRS.		IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		2c. DATE PRONOUNCED DEAD MONTH <i>7</i> DAY <i>27</i> YEAR <i>1980</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mont Gen'l Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Administrator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Rural Health</i>			
USUAL RESIDENCE (IF INSURING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4309 Land Greene St.</i>			
14. FATHER'S NAME FIRST <i>JACK</i> MIDDLE <i>GORIN</i> LAST <i>GORIN</i>				15. MOTHER'S MAIDEN NAME FIRST <i>BERTHA</i> MIDDLE <i>DEUTSCHER</i> LAST <i>DEUTSCHER</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>577-42-4172</i>		17. INFORMANT ADDRESS <i>Toby A. Gorin; 4309 Landgreen St, Rockville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> <i>4291</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>											
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John P. Rogers</i>				TITLE (SPECIFY) <i>M.D. Dep.</i>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				DATE <i>July 27 1980</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7-30-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Nat'l. Memorial Park</i>				23d. LOCATION CITY OR TOWN <i>Falls Church, Virginia</i> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i> ADDRESS				25a. DATE REC'D. BY REGISTRAR <i>JUL 31 1980</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



JUL 21 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18556

1. DECEASED NAME (TYPE OR PRINT) <b>Othmar Frank Goriup</b>				2a. DATE KNOWN OF DEATH ESTIMATED <b>July 29, 1980</b>				2b. HOUR <b>A</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 29 04</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>76 YRS.</b>	7. UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>July 31, 1980</b>	2d. HOUR <b>6:30</b>	2e. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10217 Douglas Ave</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Army, Ret'd.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>		
13a. STATE <b>Md.</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Goriup</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frieda Katz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II, Korea</b>		17. INFORMANT (Son) <b>Franklin Goriup</b>		ADDRESS <b>6244 Bright Plume, Columbia, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Myocardial Dis</b> 4291 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER <b>Dep</b>		DATE SIGNED <b>July 31, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>		ADDRESS <b>1919 Seminary Rd., Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/04/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.'l Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>		ADDRESS <b>11800 N.H. Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>			
Funeral Home <b>Silver Spring, Md.</b>									

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18-51

Name		Date	
Student		10.27.1981	
Address		U.S.A.	
City		Washington	
State		District of Columbia	
Zip		20540	
Phone		202-541-1011	
Occupation		Student	
Employer		None	
References		None	
Comments		None	

Signature: [Signature]

Date: 10.27.1981

Location: Washington, D.C.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 0 1 8 5 5 8 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WIIMA J. GRAVES								2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 18 19 80		2b. HOUR M 2:52 p M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1931		6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 7 18 19 80		24. HOUR p M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Idaho		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY High School					
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23340 Frederick Road				
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilma Kindt										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 425-54-9779		17. INFORMANT ADDRESS Howard C. Graves, Jr.				Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Bilateral pulmonary thromboembolism IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant				M.D.		MEDICAL EXAMINER		DATE SIGNED 7-20-80			
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.				ADDRESS		111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/21/80		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.				ADDRESS Damascus, Md.				25a. DATE REC'D. BY REGISTRAR JUL 23 1980		25b. REGISTRAR'S SIGNATURE			



May 26, 1931 49

U.S.A.

Idaho

Rockville

Teacher

High School

Maryland

Montgomery

Clarkburg

x

23340 Frederick Road

Charles

Henderson

Wilma

Kindt

No

425-24-9779

Howard C. Graves, Jr.

Item 13

Granston 7/21/80 Westview Mem. Park Baltimore Baltimore, Md.

Oliver L. Tolsonworth, F.A. Damascus, Md.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 8 5 5 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>STANLEY R. GREEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 22 80</b>			2b. HOUR <b>4<sup>45</sup> A.M.</b>					
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 7, 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		7 UNDER 1 YEAR MONTHS DAYS <b>7 22</b>		7 UNDER 24 HRS HOURS MIN <b>45</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Greenhouse Fabrics</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4811 Enfield Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Green</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Mannheimer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>090-07-8586</b>		17 INFORMANT ADDRESS <b>Mrs. Helen F. Green Same as item #13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic ADENOCARCINOMA</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>14 months</b> <b>16 months</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b> <b>16 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> 19 <b>79</b> to <b>July 22</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 21</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)											
22b. SIGNATURE <b>DeWitt E. DeLaster M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-22-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DeWitt E. DeLaster M.D.</b>						22e. ADDRESS <b>5500 Friendship BLVD Chevy Chase Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 24, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Mont. Maryland</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMBLEY FUNERAL HOMES, P.A. Bethesda, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OKED WITH COROWER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 6 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Lydia Frances Grover				2a DATE OF DEATH MONTH DAY YEAR 07 16 80				2b. HOUR 4 M	
3 SEX Female		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 09 03 20		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE MD				13b. COUNTY MONT.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY EWING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA RILEY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO 579-22-5495		17 INFORMANT JAMES E GROVER, 7308 WILLOW AVE. T.P.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a I certify that (1) this hospital attended the deceased from July 15, 19 80, to July 16, 19 80, that (1) (we) last saw the deceased alive on July 16, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Kijak MD						DEGREE		22c. DATE SIGNED 7-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Kijak MD						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE July 17, 1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood B.P.D. MD	
24 FUNERAL DIRECTOR NAME Tobema Funeral Home, John Walters				ADDRESS 254 Carroll St NW DC		25a. DATE REC'D. BY REGISTRAR JUL 18 1980		25b. REGISTRAR'S SIGNATURE L. J. McQuinn	



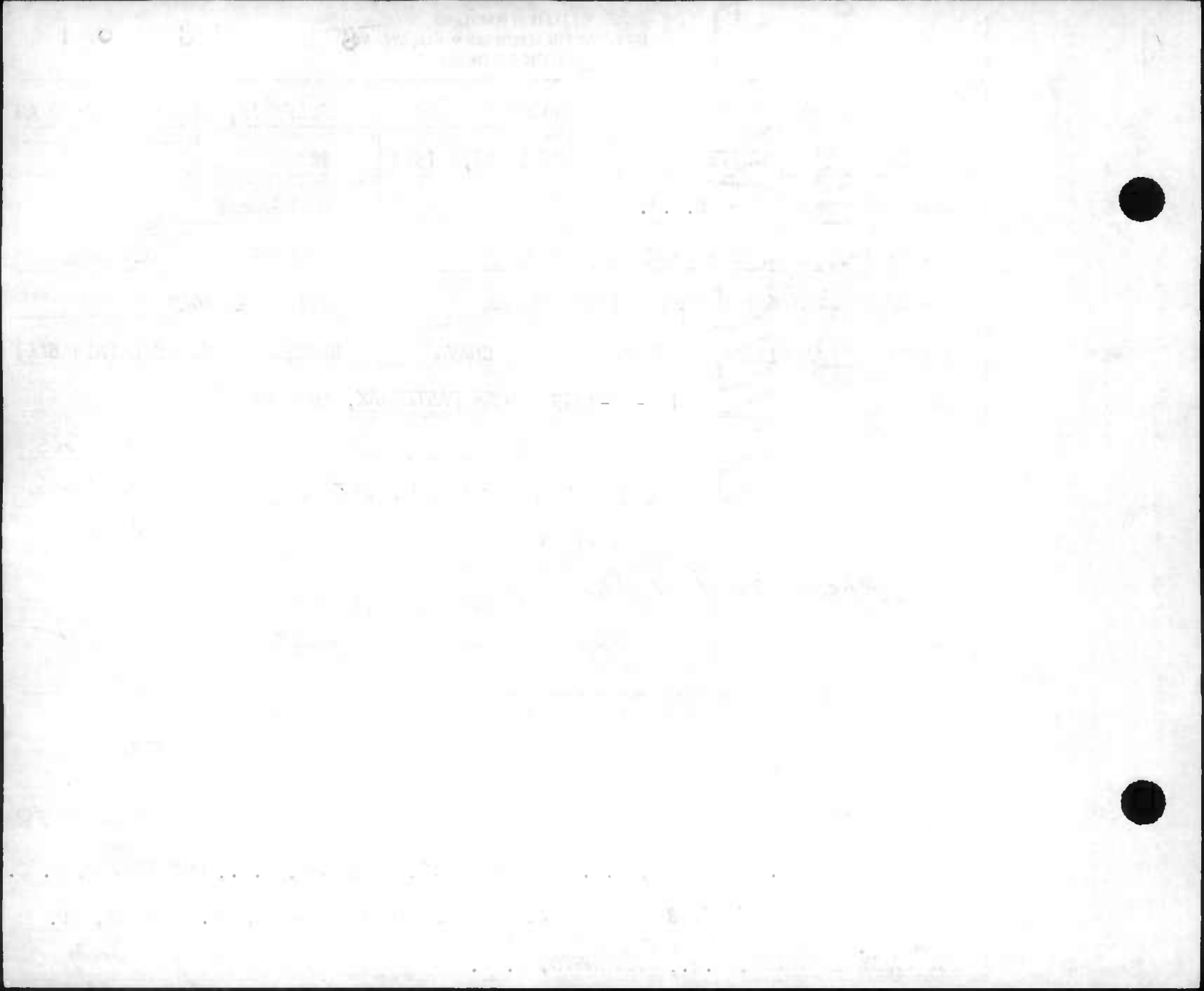
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					REG. NO. 8018561				
1. DECEASED NAME (TYPE OR PRINT) <b>MARIANNA</b>					2a. DATE OF DEATH MONTH <b>JULY</b> DAY <b>15</b> YEAR <b>1980</b>		2b. HOUR <b>3:00 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>27</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LITHUANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT "NURSING FACILITY," GIVE STREET ADDRESS) <b>CHEVY CHASE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2210 ROSS ROAD</b>	
14. FATHER'S NAME FIRST <b>ZALMON</b> MIDDLE <b>MARGOLIS</b> LAST <b>GORDON</b>					15. MOTHER'S MAIDEN NAME FIRST <b>CHAYA</b> MIDDLE <b>REIZEL</b> LAST <b>(UNASCERTAINABLE)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>164-07-2855</b>		17. INFORMANT ADDRESS <b>MUSA PASTERNAK, same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SEPSIS</b> 438- DUE TO, OR AS A CONSEQUENCE OF (b) <b>DECUBITUS ULCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>STROKE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b> <b>3 MOS.</b> <b>1 YR.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid Arthritis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>80</b> to <b>July</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>12 JULY</b> , 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22b. SIGNATURE <b>Lawrence H. Schinker, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>15 JULY 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE H. SCHINKER, M.D.</b>				22e. ADDRESS <b>5401 WESTERN AVENUE, N.W., WASHINGTON, D. C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/18/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ADELPHI, PR. GEORGES, MD.</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N.W., WASHINGTON D. C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

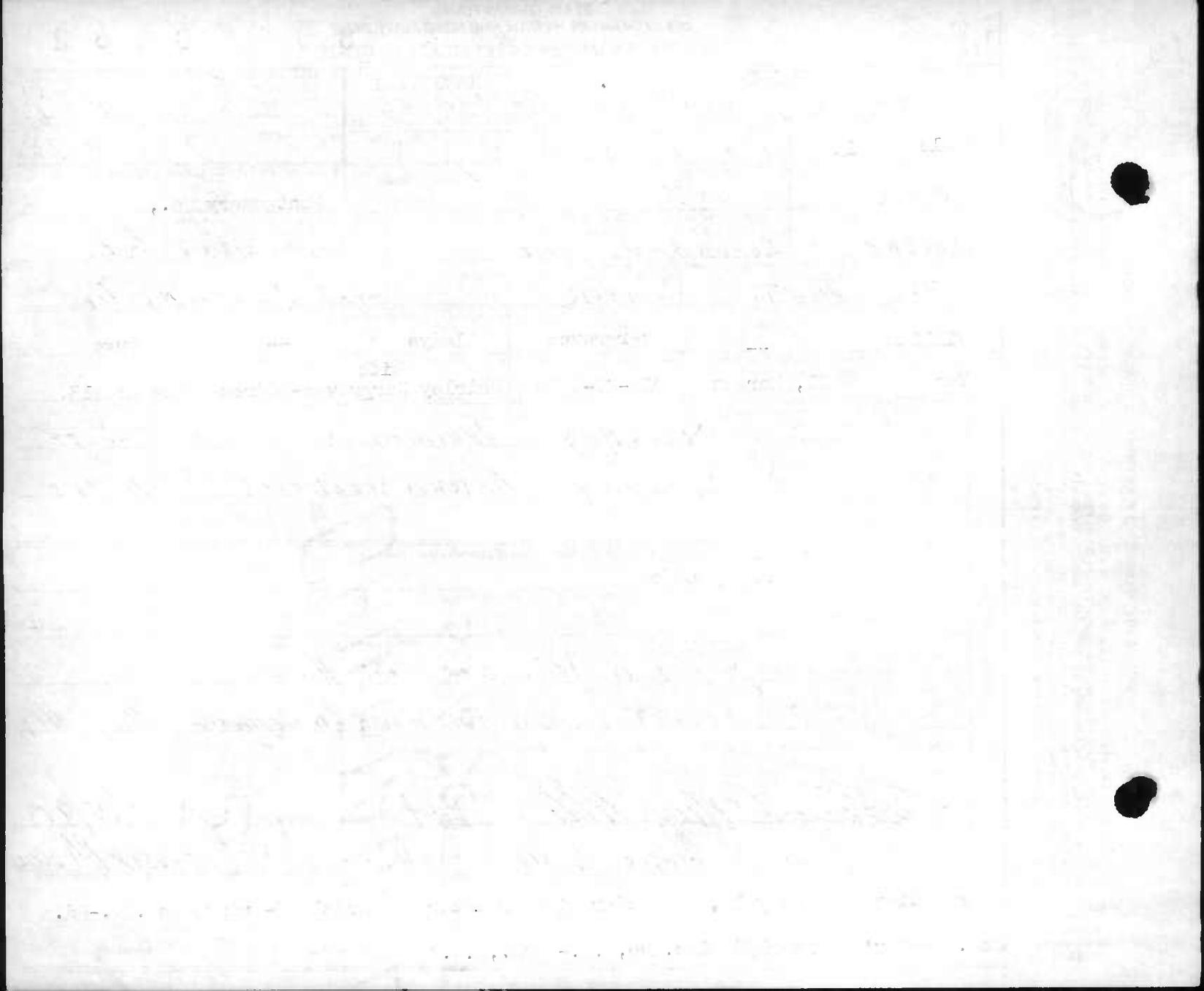




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18562

1. DECEASED NAME (TYPE OR PRINT) <b>PHILIP</b>		FIRST <b>PHILIP</b>		MIDDLE <b>CLIFFORD</b>		LAST <b>HARGRAVES</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 15 1980</b>		2b. HOUR <b>7:55 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 7 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUMNER HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MANAGEMENT G.E.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>MDT.</b>		13c. CITY OR TOWN <b>SUMNER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4938 SENTINEL DR</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>--</b> LAST <b>Hargraves</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>--</b> LAST <b>Tugo</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>022-20-3796</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Shirley Hargraves-Address same as #13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 YRS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>NONE</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 15 1980 7 PM</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>IN CAR HIT HOUSE</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STREET</b>		21f. LOCATION STREET <b>3300 TUSCARAWA RD</b>		CITY OR TOWN <b>BETHESDA</b>		COUNTY <b>MDT</b> STATE <b>MD</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francis C Mayke Jr</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>820 Wisconsin Ave Bethesda Md 20814</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C Mayke Jr</b>				ADDRESS <b>820 Wisconsin Ave Bethesda Md 20814</b>				DATE SIGNED <b>7/15/80</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 17, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland-Prince Geo. Co.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Jos. Gawler's Sons</b> ADDRESS <b>5130 Wisc. Ave, N.W.-Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			



Item 8 G 546 8/19/80 GB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8018563  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MILTON		MIDDLE PATRICK		LAST HARLOW		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH 7		DAY 6		YEAR 1980		2d. HOUR 6:45 PM					
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 9		DAY 10		YEAR 11		6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 7		DAY 6		YEAR 1980		7d. HOUR 7:20 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY													
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY painter															
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 436 MacArthur Drive													
14. FATHER'S NAME FIRST Walter		MIDDLE		LAST Harlow		15. MOTHER'S MAIDEN NAME FIRST Anna		MIDDLE Marie		LAST Ficher											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Marian Harlow same as 13e																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Acute + Chronic Alcoholism</u>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																					
ACTUAL SIGNATURE John G. Ball		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER DATE SIGNED July 6, 1980																	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball		ADDRESS Old Georgetown Rd. Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, COUNTY Maryland															
24. FUNERAL DIRECTOR Name Elyson Wheeler Funeral Home, Inc.		ADDRESS 1331 Rockville Pike Rockville, Maryland		25. DATE RECEIVED BY REGISTRAR JUL 10 1980		26. REGISTRAR'S SIGNATURE															

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATHWALTER EDWARD HART  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter Edward Hart			2a. DATE KNOWN OF DEATH ESTIMATED July 22, 1980			2b. HOUR 6:30 PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Jan 4 29 51 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD July 22, 1980		
7a. BIRTHPLACE (STATE OR COUNTY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 445 Boyd Ave				12a. USUAL OCCUPATION (TYPE OF WORK) Credit Manager		12b. INDUSTRY Retail
13a. STATE Md			13b. COUNTY Montgomery	13c. CITY OR TOWN Tak Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 445 Boyd Ave		
14. FATHER'S NAME John			15. MOTHER'S MIDDLE NAME Lucy			15. MOTHER'S LAST NAME Burgee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W. # 2 578-34-5313			17. INFORMANT BERNADINE PENNINGTON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> 2501 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Robert Rogen			TITLE (SPECIFY) M.D. Dep			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE July 25, 1980			23c. NAME OF CEMETERY OR CREMATORY Beltsdale V.A.		
23d. LOCATION Beltsdale			23e. COUNTY Md.			23f. REGISTRAR'S SIGNATURE Murray Melby		

UNIVERSITY OF TORONTO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 8 5 6 5	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Mary Hassin		MONTH DAY YEAR 7/24/80		7:45 A.M.	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH AUGUST 25, 1896	6. AGE (IN YEARS, LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB GOLDSTEIN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA GUSSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-14-3083	17 INFORMANT ADDRESS ELEANOR HARMON 11102 BUCKNELL DRIVE, WHEATON, MARYLAND			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro intestinal bleeding</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pancreatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hour 3 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the physician) attended the deceased from <u>2/4</u> 19 <u>65</u> to <u>7/24</u> 19 <u>80</u> , that (I) (the) last saw the deceased alive on <u>7/9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Herbert Wexler</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/28/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert Wexler		22e. ADDRESS 1800 Eye Street, N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/28/1980	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D.C.		25. DATE RECEIVED BY REGISTRAR 7/30/80			



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1401 BLAIR WILL ROAD	SILVER SPRING	ARLANS MONTGOMERY	JACOB
SALESLEY	UNIVERSITY	WHEATON	NO
WENT. STONE			
MONTGOMERY			
1101 BICKELL DRIVE	COLLEGE		
WHEATON, MARYLAND	ELEANOR HARRISON	372-14-1088	
GUSTIN	BERNIE		

Handwritten notes and signatures are present in the lower half of the page, including a large signature that appears to read "John C. [illegible]".

201 30 1980

224 CARROLL STREET, N.E., WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 6 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna P. Hauptmann			2a. DATE OF DEATH MONTH DAY YEAR 7/30/80		2b. HOUR 14:45 P M	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sep. 23, 1881		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D.C.	13b. COUNTY	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 216 Aspen Street, N.W. 20012		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Rauch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 578-36-2380	17. INFORMANT Daughter Virginia H. Walker same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal failure 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Old age APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Osteoporosis with multiple old compression fractures thoracic & lumbar spine						
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1973, 19, to July 30, 1980, that (I) (we) last saw the deceased alive on July 28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Sydney Leventhal, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/30/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sydney Leventhal, M.D.		22e. ADDRESS Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE Anthony McBrady		
500 University Blvd., W. Silver Spring, Md.						

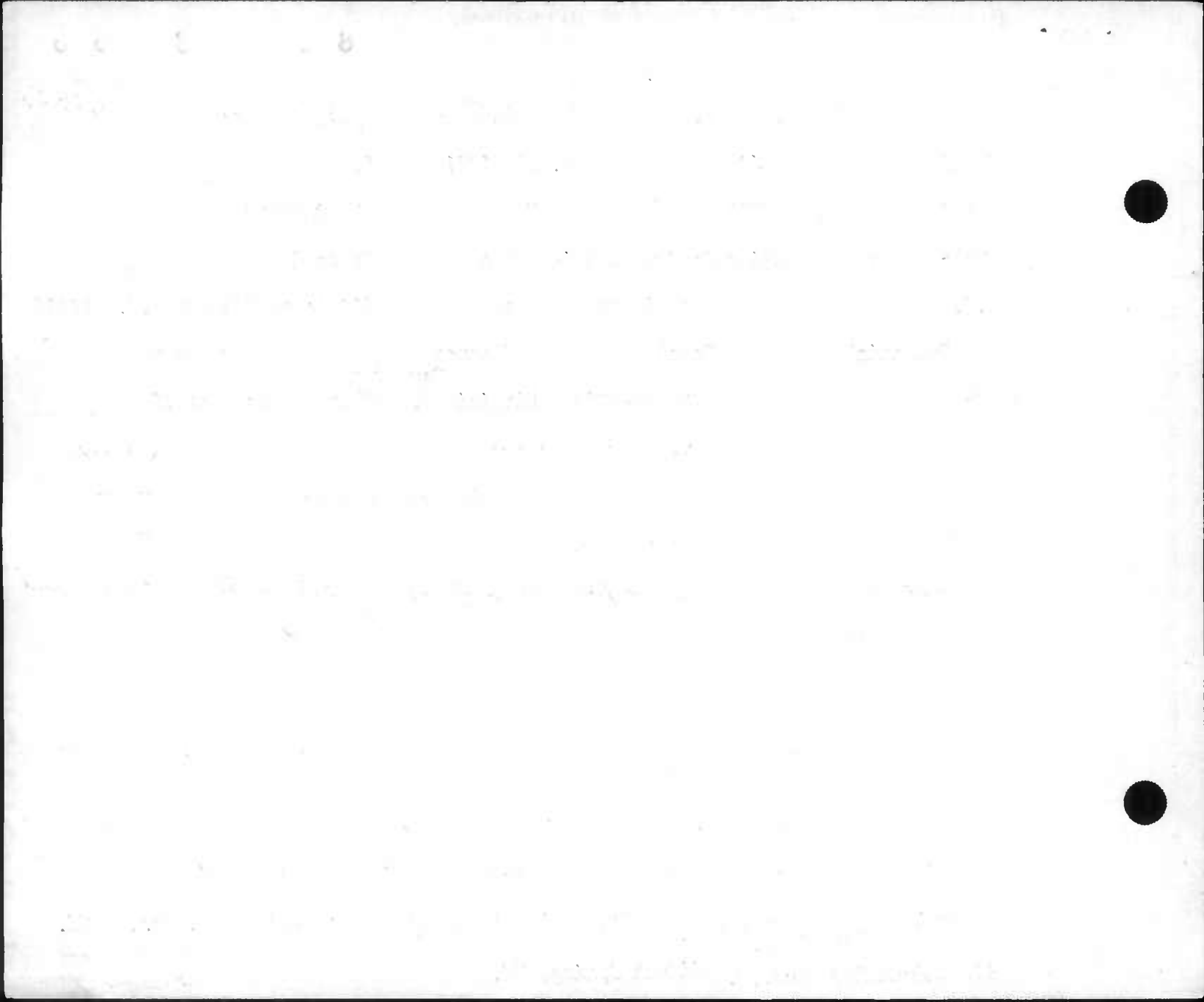


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

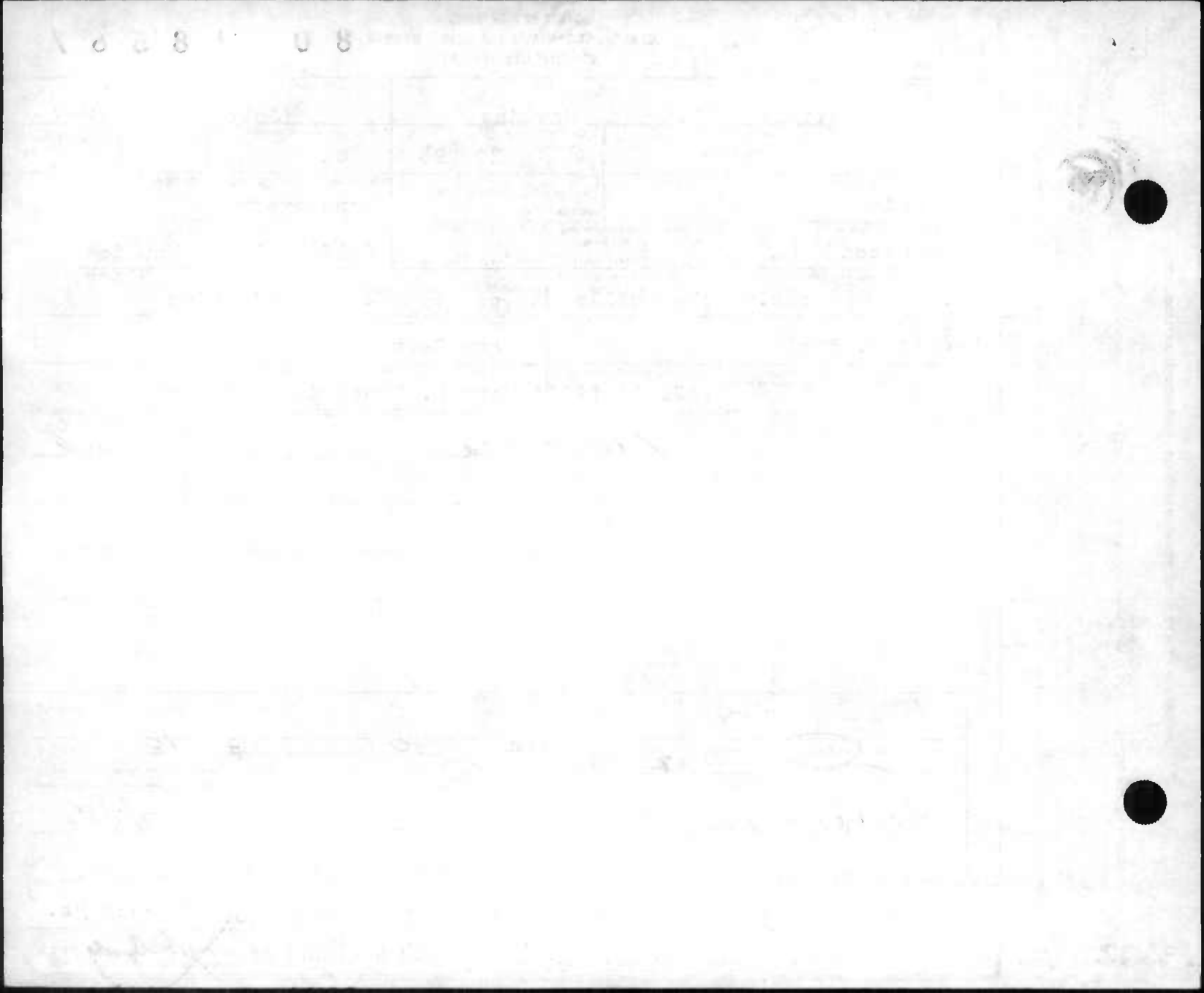
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 6 7

REG. NO.

1 - FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lunelle F. Hawkins		2a. DATE OF DEATH MONTH DAY YEAR July 3, 1980		2b. HOUR 10:00 A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 20 98		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Glass	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas W. Ryals		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary George		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO 579 44 9938	
17 INFORMANT Same as above		17 INFORMANT A Mary T. Panossian (Sister)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486 - DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 6/12/80 to 7/3/80, that (1) (we) last saw the deceased on 7/3/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Barry N. Rosenbaum				22c. ADDRESS 3720 Farragut Ave., Kensington, Md.		22d. DATE SIGNED 7/3/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/80		23c. NAME OF CEMETERY OR CREMATORY Lyles Bapt. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kent Store Pluvana Va.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS 11800 N.H.Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUL 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



#5, per call w/F.H.

FOR 7/15/80 kam  
1- STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>RILLA</u> MIDDLE <u>—</u> LAST <u>HAYES</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>7-5-80</u>		2b. HOUR <u>10 A.M.</u>	
3. SEX <u>FEMALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>March 27 1892</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>North Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.		10. CITY OR TOWN OF DEATH <u>Wheaton</u>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY NURSING HOME</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>house wife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Gaithersburg</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS <u>Rt. 1 Box 234 Gaithersburg, Md.</u>	
14. FATHER'S NAME FIRST <u>Ervin</u> MIDDLE <u>—</u> LAST <u>Proctor</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Rilla</u> MIDDLE <u>—</u> LAST <u>Long</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>239 36 0610</u>		17. INFORMANT <u>Virginia Nusbaum</u> ADDRESS <u>Same as 13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>—</u>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22/1979</u> to <u>7/5/80</u> , that (we) lost saw the deceased alive on <u>6/4/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) (saw) view the body after death.					
22b. SIGNATURE <u>Steven A. Burger, MD</u>		DEGREE (for M. Patient) MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7-5-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven A. Burger, MD</u>		22e. ADDRESS <u>2601 Medical Park Dr. Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>July 5 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Greensboro Guilford N.C.</u>		24. FUNERAL DIRECTOR NAME <u>Francis H. Barber</u> ADDRESS <u>Box 998 Laytonsville, Md. 20760</u>			
24a. DATE REC'D. BY REGISTRAR <u>JUL 9 1980</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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5. To find

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Virginia E. Hebb.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7/24/80</i>			2b. HOUR <i>1:35 A.M.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT 13 1884</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>95</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Civil Servant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Pat. Off.</i>	
13a. STATE <i>-</i>				13b. COUNTY <i>-</i>		13c. CITY OR TOWN <i>Wash. D.C.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard M. Hebb</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Laura - Combs</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Unavailable</i>		17. INFORMANT (nephew) ADDRESS <i>John Wayles Kennedy, Boca Raton, Fla.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 2639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <i>INANITION</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 WK</i> <i>1 YEARS</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>CHRONIC BRAIN SYNDROME, SEVERE</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>MAY 1980</i> to <i>7/24 1980</i> , that (1) (we) last saw the deceased alive on <i>7/23/80</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ralph M. Coan M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>7/24/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RALPH M. COAN M.D.</i>				22e. ADDRESS <i>4400 EAST WEST HWY BETHESDA, MD. 20014</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>July 26 '80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Gee. Epis. Church Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Valley Lee, St. Marys Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>DeVol Funeral Home 2222 Wisc Ave. Washington D.C.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 04 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Pietro J. McQuinn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE UNITED STATES OF AMERICA

Richard



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 8 5 7 0			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HAZEL CLARA HELLER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 15, 1980</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 10, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
13a. STATE <b>New York</b>		13b. COUNTY <b>West Chester</b>		13c. CITY OR TOWN <b>Katonah</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Rlink</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Schmidt</b>		16. STREET ADDRESS <b>Route #4 Oak Drive, 10536</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>060-09-6596</b>		17. INFORMANT ADDRESS <b>Mr. Herman Heller, Husband (same as above)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> 4239 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Temporal</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Temporal</b> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1980</b> to <b>July 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two (did) did not view the body after death, <b>xx</b> )							
22b. SIGNATURE <b>Glenn Barnhart</b> M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>16 Jul 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Glenn Barnhart MD</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ivandell Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Somers N.Y.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Homes, P.A.</b>				25a. DATE REC'D BY REGISTRAR <b>JUL 18 1980</b>			
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 5 7 1

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frances HELMIG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 21 1980</b>			2b. HOUR <b>1:10P M</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 9 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Therapist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>New Jersey</b>				13b. COUNTY <b>Atlantic</b>		13c. CITY OR TOWN <b>Pleasantville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>34 East Ridgewood Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Helmig</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie H. Couse</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			
16b. SOCIAL SECURITY NO. <b>WW II 155 01 1993</b>				17. INFORMANT <b>Camille Hamilton</b>				18. ADDRESS <b>Pleasantville, N.J. Hamilton 35 East Ridgewood Ave.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 MIN</b>	
7159 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b) <b>PROBABLE PULMONARY EMBOLUS.</b>	
		c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>17 July 1980</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DEGEN. ARTHRITIS OF KNEE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>July 15</b> , 19 <b>80</b> , to <b>July 21</b> , 19 <b>80</b> , that (b) (we) last saw the deceased alive on <b>July 21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) not view the body after death.							
22b. SIGNATURE <b>Alice M. Martinson MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>July 22 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alice M. Martinson</b>				22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul. 26, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasantville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pleasantville Atlantic N.J.</b>	
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24. FUNERAL DIRECTOR NAME <b>Robt. A. Pumphrey</b>		ADDRESS <b>Funeral Home Bethesda, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1880 8 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The deceased must be retained by the hospital or attending physician.

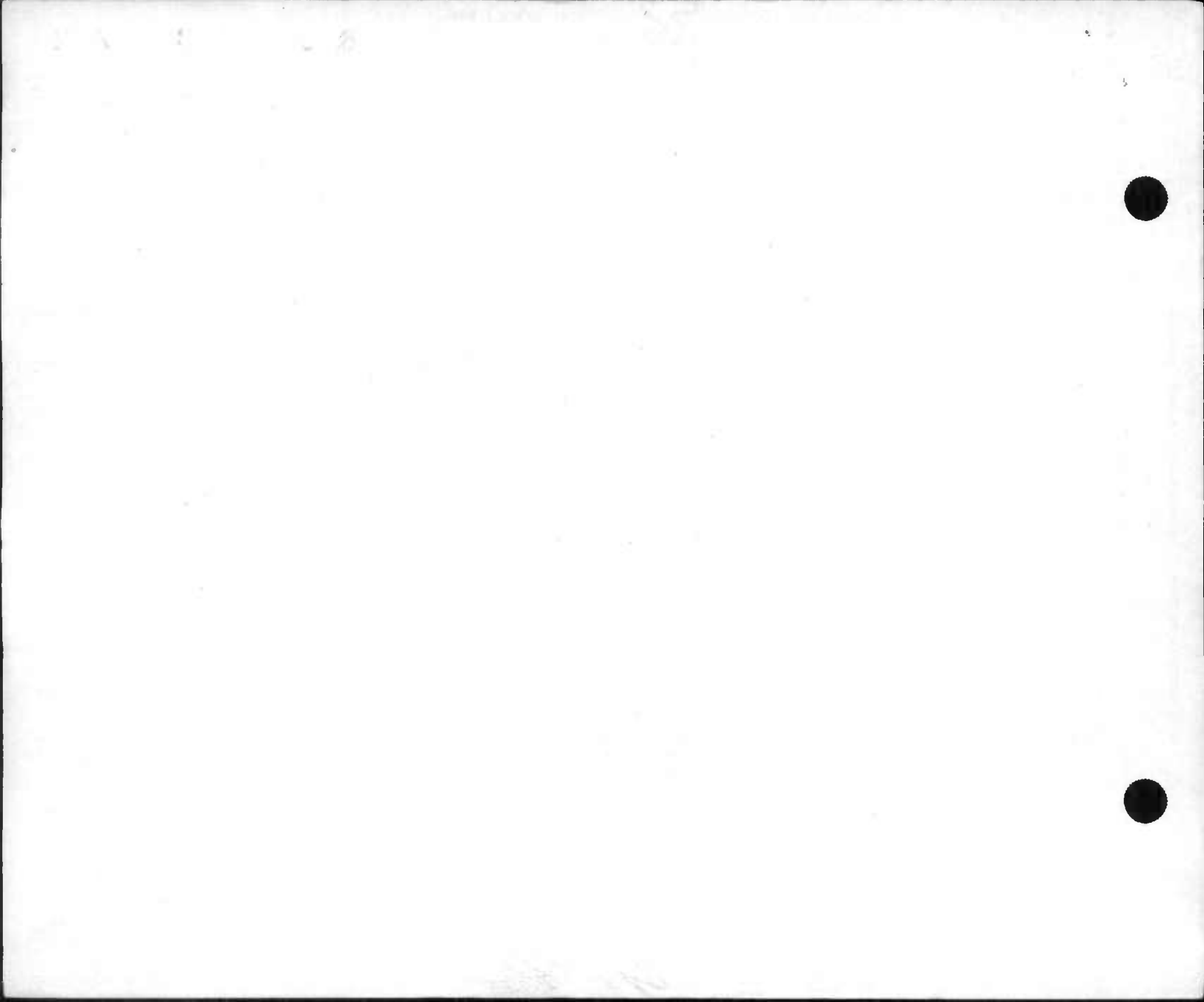
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alsey L. High			2a. DATE OF DEATH MONTH DAY YEAR July 20/80		2b. HOUR 7:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 8 <sup>th</sup> 1900	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8101 Eastern Avenue, Apt. 12		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator	12b. KIND OF BUSINESS OR INDUSTRY Machines Vending	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Springs	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8101 Eastern Avenue,	
14. FATHER'S NAME FIRST MIDDLE LAST A. W. High		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth High			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none	17. INFORMANT (wife) ADDRESS Verla T. High- (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular accident Right - June 1979</u>					
19a. DATE OF OPERATION 7-20-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-20-80, 1980, to 7-20-80, 1980, that (I) (we) last saw the deceased alive on 7-20-80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Roland Imperial, MD.				22c. DATE SIGNED 7-21-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roland Imperial, MD.				22e. ADDRESS 4977 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 22, 1980	23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Wilson N. Car.	25a. DATE REC'D. BY REGISTRAR JUL 23 1980	
24. FUNERAL HOME B. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25b. REGISTRAR'S SIGNATURE [Signature]	



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>ROSE</i> MIDDLE <i>EVA</i> LAST <i>HOFFMAN</i>		2a. DATE OF DEATH MONTH <i>7</i> DAY <i>31</i> YEAR <i>80</i>		2b. HOUR <i>4:38</i> PM	
3. SEX <i>Female</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH <i>7</i> DAY <i>29</i> YEAR <i>1884</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>State unknown</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		13b. CITY OR TOWN <i>Silver Spring</i>		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Unknown</i> MIDDLE <i></i> LAST <i></i>		15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i> MIDDLE <i></i> LAST <i></i>		16. ADDRESS <i>Woodbine, Md.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-12-3156</i>		17. INFORMANT <i>Wm. L. Fallon</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>Cardiac arrest</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Actual Fibrillation</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Right Bundle Branch Block</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture left femur</i>					
19a. DATE OF OPERATION <i>7.31.80</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture Femur</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 7 24 1980</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>Pathologic Fracture</i>		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Nursing Home</i>	
21f. LOCATION STREET <i>1000 DALEVIEW DR.</i> CITY OR TOWN <i>WOODBINE</i> COUNTY <i>M</i> STATE <i>MD</i>		21g. LOCATION STREET <i>ALTHEA WOODBINE</i> CITY OR TOWN <i>SP.</i> COUNTY <i>M</i> STATE <i>MD</i>		21h. LOCATION STREET <i>1000 DALEVIEW DR.</i> CITY OR TOWN <i>WOODBINE</i> COUNTY <i>M</i> STATE <i>MD</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/31</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <i>7/31</i> 19 <i>80</i> , and that (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Roland J. Cavanaugh MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8.3.80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Roland J. Cavanaugh</i>		22e. ADDRESS <i>1109 XXXXX Spring St. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/6/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Arlington</i> COUNTY <i>Virginia</i> STATE <i>VA</i>		24. FUNERAL DIRECTOR NAME <i>Wheeler Funeral Home, Inc.</i> ADDRESS <i>1331 Rockville Pike Rockville, Maryland</i>			
25. DATE RECD. BY REGISTRAR <i>AUG 11 1980</i>		26. DATE RECD. BY REGISTRAR <i>AUG 11 1980</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 1 8 5 7 4			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) HENSON HOPKINS					2a. DATE OF DEATH MONTH DAY YEAR JULY 9 80					2b. HOUR 1:20 PM			
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR FEB. 4, 1902			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Montg		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-16-7139		17. INFORMANT ADDRESS Ruth CROSS - 827 Quince Orchard Blvd. Gaithersburg, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR THROMBOSIS 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS			
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from April 19 77, to July 9 19 80, that (I) (the) lost saw the deceased alive on July 1 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Walter E. Goetz								22c. DATE SIGNED 9 July 80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZTH MD								22e. ADDRESS 2309 SHOREFIELD ROAD SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-12-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md.					
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Wash. Rockville, Md.		25. DATE REC'D. BY REGISTRAR JUL - 5 1980		25b. REGISTRAR'S SIGNATURE				

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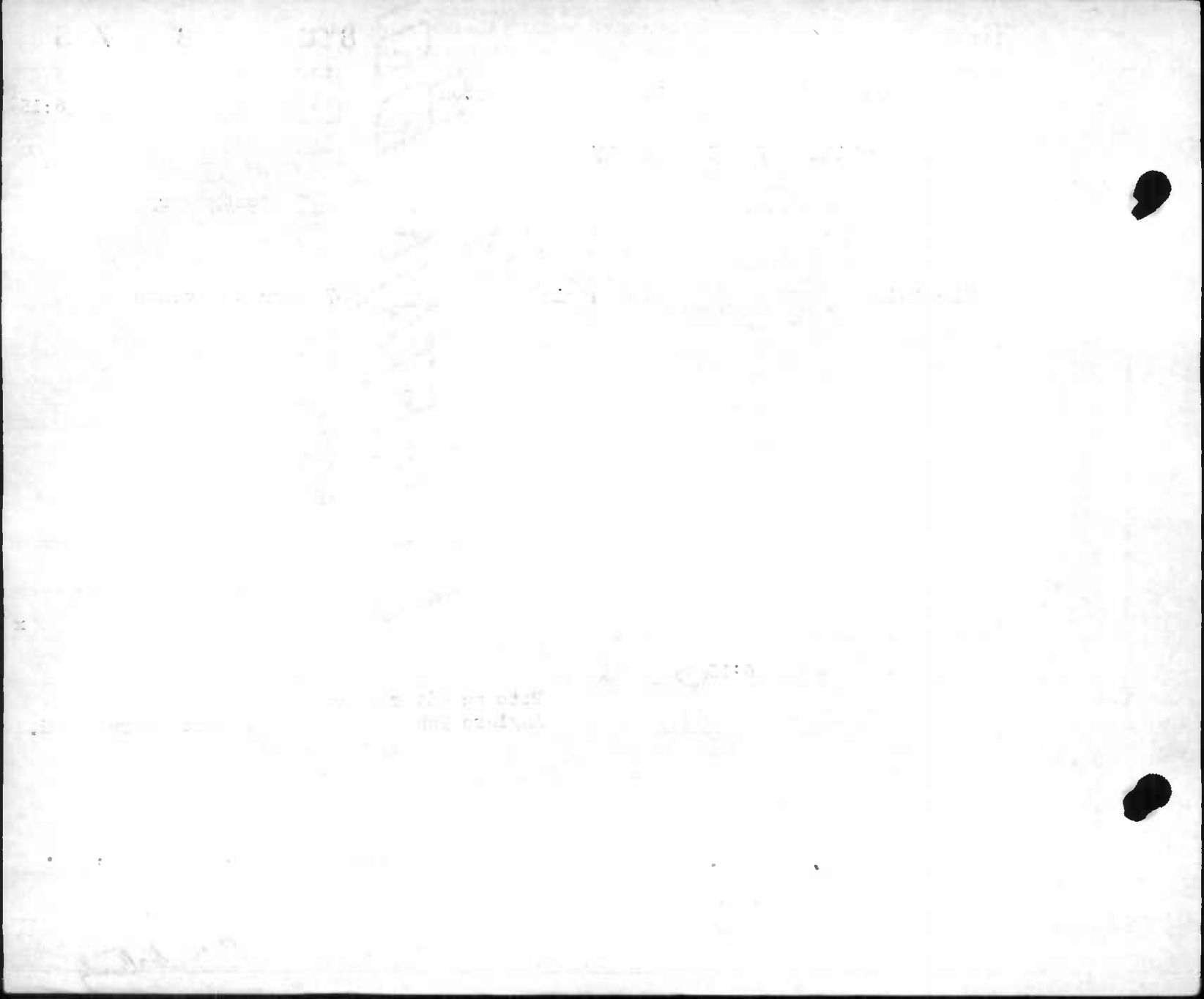
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18575	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Benjamin Keith Horton						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-20-1980		2b. HOUR 6:15 PM			
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 7 3 63	6. AGE (IN YEARS) LAST BIRTHDAY 17 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD July 22 1980		2d. HOUR 11 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac River Anglers Inn.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Virginia		13b. COUNTY None		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2507 Terrett Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Horton						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Ellen M. Horton Same as item 13 Mother									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9102 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:15 PM 7-20-1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Slipped when Wading in River							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) River		21f. LOCATION CITY OR TOWN COUNTY STATE Potomac River above Anglers Inn Potomac Montgomery Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED July 23 1980					
EXAMINER'S NAME (TYPE OR PRINT) Dr. John G. Ball				ADDRESS Old Georgetown Rd. Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/25/80		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.					
24. FUNERAL DIRECTOR NAME Walter J. Hall				ADDRESS Cameron & Alfred Sts				25a. DATE RECD. BY REGISTRAR JUL 29 1980		25b. REGISTRAR'S SIGNATURE L. H. Hall			
Cunningham Funeral Home, Inc. Alex., Va.													





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. John G. Ball

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George R. Houston, Sr.			2a. DATE OF DEATH MONTH DAY YEAR July 15, 1980			2b. HOUR A 11:45M		
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1917	6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian			12b. KIND OF BUSINESS OR INDUSTRY Library of Congress	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6212 Madawaska Road			
14 FATHER'S NAME FIRST MIDDLE LAST Samuel R. Houston			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Corner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			16b. SOCIAL SECURITY NO 577 54 1177		17 INFORMANT ADDRESS Lillian R. Houston same as item 13			

## MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHOGENIC CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 MINUTES 8 MONTHS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). POST RADIATION FIBROSIS AND ESOPHAGITIS		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from MARCH 18 19 71 to JULY 15 19 80, that (I) (we) last saw the deceased alive on JULY 9 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Edward W. Youngblood, M.D.		22c. DATE SIGNED July 15, 1980
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward W. Youngblood, M.D.		22e. ADDRESS 4900 Massachusetts Ave. N.W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE July 19, 1980	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		25a. DATE REC'D. BY REGISTRAR JUL 18 1980	25b. REGISTRAR'S SIGNATURE [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 5 7 8	
1- STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Charles B. Howard					2a. DATE OF DEATH MONTH DAY YEAR 7 17 80			2b. HOUR 7:00 <sup>AM</sup>			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 31 83		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1042 Quince Orchard Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Farmer			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1042 Quince Orchard Road				
14 FATHER'S NAME FIRST MIDDLE LAST Daniel Howard					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. -- -- 220 34 7733		17 INFORMANT ADDRESS Gaithersburg, Md. Hazel Mills 1028 Quince Orchard Rd.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>4409</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old age</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>none</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3</u> 19 <u>76</u> , to <u>July 17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John O. Robben</u> for <u>Dr. John Fawcett</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>7/17/80</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John O. Robben					22e. ADDRESS 10400 Conn. Ave. Kensington, Md. 20795						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Maryland					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR JUL 21 1980		25b. REGISTRAR'S SIGNATURE <u>John Fawcett</u>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edwyna S. HUDSON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 8 80</i>		2b. HOUR <i>3 05 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 3, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>80</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>High Point NC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rockville, md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Collingswood Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Nurse.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <i>MD</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert A. Strayhorn.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Maynard.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>216-38-6133</i>		17. INFORMANT ADDRESS <i>Oakton, Virginia.</i> <i>Frank Hudson Jr. 11420 Vale Rd.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal metastatic Ca colon</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1980</i>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>July 1980</i> P.M. <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1900</i> 19 <i>July 1980</i> , 19 <i>July 1980</i> , that (I) (we) last saw the deceased alive on <i>June 1900</i> 19 <i>July 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i> MD		22c. DATE SIGNED <i>7/8/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>OSOTH LERAGUL, MD</i>		22e. ADDRESS <i>7405 arlington Rd, Bethesda, Md</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 11-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bladensburg Rd. P. Geo.</i>	
24. FUNERAL DIRECTOR <i>[Signature]</i> <i>Takoma Funeral Home.</i>				25. DATE RECEIVED BY REGISTRAR <i>JUL 11 1980</i>			
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				27. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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OFFICE OF THE ATTORNEY GENERAL  
DETROIT, MICHIGAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 8 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVA E. Hurd</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 25/80</b>		2b. HOUR P <b>1342 M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 29 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS <b>80</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD</b>	13b. COUNTY <b>MONTG</b>	13c. CITY OR TOWN <b>ROCKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7712 BAEDERWOOD TERR</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Hellwege</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Lippert</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>174-07-4597</b>		17. INFORMANT <b>same as 13e</b> <b>LAUVONNE HERD</b> <b>Rockville MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4029 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/23/80</b> , 19 <b>80</b> , to <b>7/25</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/25/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Cheryl Winchell</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/26/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cheryl Winchell</b>		22e. ADDRESS <b>19241 Montgomery Village Ave. Gaithersburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1980 July 29,</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Allegany Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Allegany, New York</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumfrey</b>		Rockville, Maryland <b>Pumfrey Funeral Homes, P.A.</b>		25a. DATE REG'D. BY REGISTRAR <b>JUL 30 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony M. [Signature]</b>	

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRYETE HURST</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-25-80</b>		2b. HOUR 7 <sup>03</sup> <sub>4M</sub>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7-4-39</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Damascus</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>10408 Maynard Court</b>		14 FATHER'S NAME FIRST MIDDLE LAST <b>James Koch</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Zaffos</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>448 36 3073</b>		17 INFORMANT <b>Dr. M. Wayne Hurst</b>		ADDRESS <b>Item 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>1749 Metastatic Carcinoma</b> IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b> <b>4 YEARS</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 77</b> to <b>JULY 25 1980</b> , that (I) (we) last saw the deceased alive on <b>7/25 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>G. Lennard Gold, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/25/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Lennard Gold, M.D.</b>				22e. ADDRESS <b>8630 Fenton St., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/29/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oklahoma City, Oklahoma</b>	
24 FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, P.A. Damascus, Md.</b>				25a. DATE RECEIVED BY FUNERAL HOME <b>JUL 25 1980</b>		25b. FUNERAL HOME SIGNATURE <b></b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 8 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis C. Hyman			2a DATE OF DEATH MONTH DAY YEAR 7/12/80			2b HOUR 8:47am				
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 11/17/17		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10 CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired U.S. Gov't		12b KIND OF BUSINESS OR INDUSTRY Government		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 222 Blanford Street	
14 FATHER'S NAME FIRST MIDDLE LAST Francis Claude Hyman Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Ellington							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 718-12-2329		17 INFORMANT 222 Blanford Street Ida Ruth Hyman Rockville, Md. 20850						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary arrest</i> 3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>tachyarrhythmic atrial</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic heart disease</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>chronic obstructive pulmonary disease - Respiratory failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 19 <i>74</i> , to <i>7-12</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7-4</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>V. J. Bucy / R. Macon M.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 7-12-80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Bucy				22e ADDRESS 809 VEIR'S Mill Rd						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/15/80		23c NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince George Md.				
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home				24b ADDRESS 1331 Rockville Pike Rockville, Md.		25a DATE REC'D. BY REGISTRAR JUL 16 1980		25b REGISTRAR'S SIGNATURE <i>Robert A. Bucy</i>		

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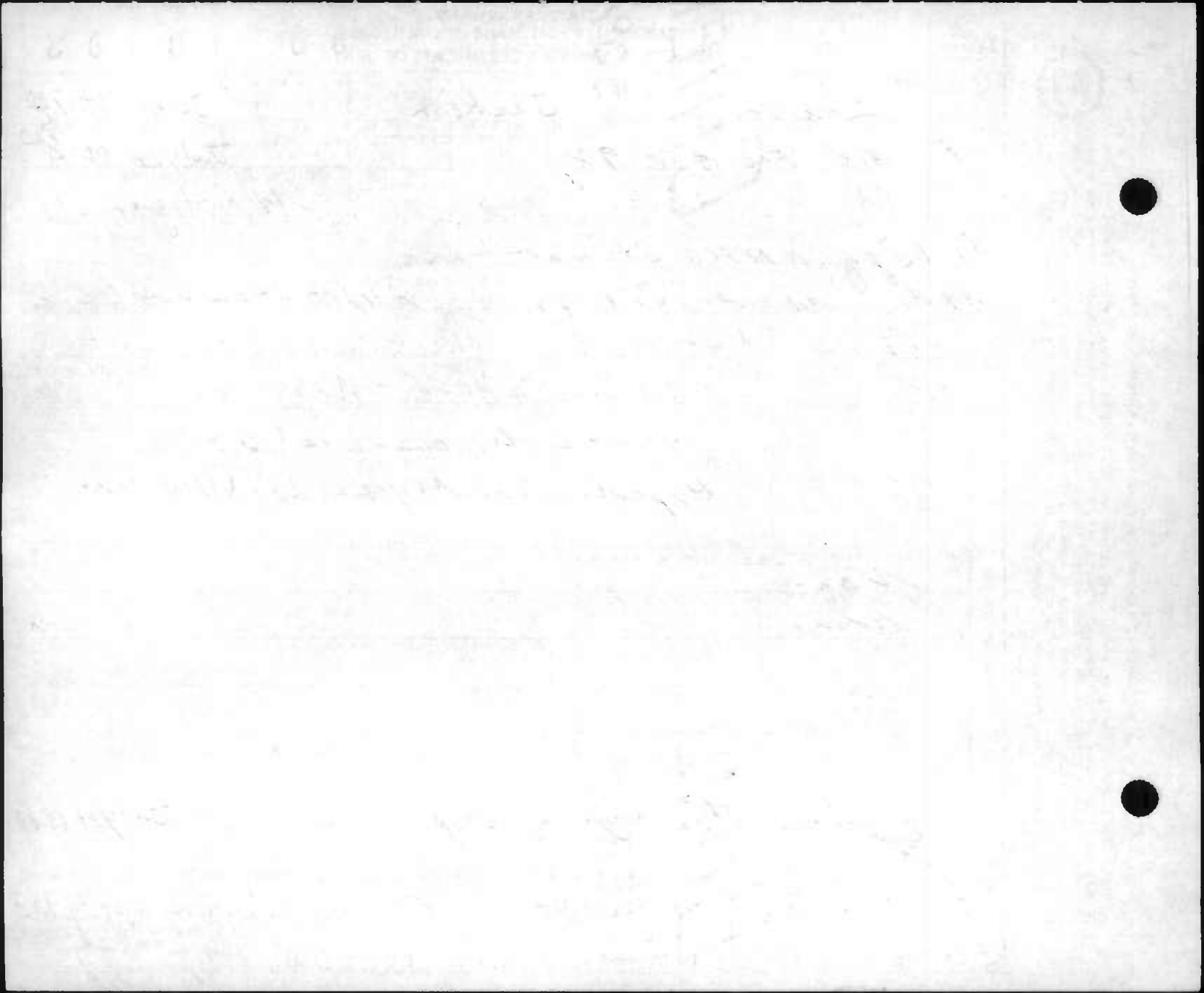
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18583

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Louise Jackson</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 14, 1980</b>			2b. HOUR <b>9:40 AM</b>		
3. SEX <b>F</b>	4. RACE <b>Blk</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 15 88</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>July 14, 1980</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>S. L. Spg.</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11310 Stewart Lane</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>S. L. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELIAS MATTHEWS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCINDA STEWART</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-74-6974</b>			17. INFORMANT ADDRESS <b>HARRIET WASHINGTON 11311 Stewart Lane</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Inf.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Hypertensive Myocardial Inf.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4029</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>								
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John D. Rogers</b>			TITLE (SPECIFY) <b>M.D. Asst.</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED <b>July 14, 1980</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 17, 1980</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Good Hope Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montg Md.</b>			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE <b>George R. Snowden</b>		
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>			ADDRESS <b>246 N. Washington Rockville, Md.</b>			JUL 22 1980		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18584			
1. DECEASED NAME (TYPE OR PRINT) <b>Lotus Mozelle Jaffe</b>										2a. DATE KNOWN OF DEATH <b>7-16-80</b>		2b. HOUR <b>9:50 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Nov. 15, 1932</b>		6. AGE (IN YEARS) <b>47 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>July 16, 1980</b>		2d. HOUR <b>9:35 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wyoming</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5708 Beech Ave</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Editor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>F.A.S.E.B.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5708 Beech Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Ogle</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta Lotus Emmons</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>152-24-3605</b>		17. INFORMANT ADDRESS <b>Daniel L. Jaffe Same as item #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia - Hanging</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>self-inflicted.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:30 AM 7-16-80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Hung self with rope</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5708 Beech Ave Bethesda Mont. MD</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>July 16, 1980</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd.</b>				Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park Rockville, Mont., MD.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1980</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony J. [Signature]</b>					

NOTATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

REG. NO.

1 8 5 8 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES Harold JENNINGS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July, 29 80</b>		2b. HOUR <b>10<sup>30</sup>A</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1904</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7 UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		8 UNDER 24 HRS HOURS MIN. <b>MIN</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County, MD</b>		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>4116 Blackthorn Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Orville Jennings</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Retta I. McIntosh</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>494-22-0930</b>		17 INFORMANT ADDRESS <b>Pauline W. Jennings Same as item #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 5324 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Upper Gastrointestinal Bleeding 2 Days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Duodenal Ulcer 2 Days</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 29</b> 19 <b>80</b> to <b>July 29</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 29</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Thomas N. Carter M.D.</b>		22c. DEGREE <b>M.D.</b>		22d. DATE SIGNED <b>7/29/80</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas N. Carter M.D.</b>		22f. ADDRESS <b>5530 Wigwam Ave Ch Ph. Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince Geo. MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>				
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>		25a. REGISTRAR'S SIGNATURE <b>L. J. McCreedy</b>				







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18b G547 9/4/80 dad

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 5 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GARNER LEE Jernigan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-26-80</b>		2b. HOUR <b>9:05 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 23, 1908</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County MD</b>			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Security Officer US Gov't.</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSP.</b>			12. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>D.C.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur B. Jernigan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Marshburn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>577-22-4475</b>		17. INFORMANT ADDRESS <b>E. Lucille Vaughan, Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>496- Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Corn/Sunburn</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>10 yrs</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>June 26, 1980</b> to <b>July 26, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Kirk F. ...</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/26/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KIRK F. ...</b>		22e. ADDRESS <b>9410 Old Georgetown Rd Bethesda, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensburg, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>				
25. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		26. REGISTRAR'S SIGNATURE <b>Anthony ...</b>				

1980 0 0 204

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAMH-17  
(VIR A15 ME (S))  
15M/7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 5 8 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Henry Johnson</i>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>July 20 1980</i>				2b. HOUR MIN <i>1200 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Mar 25 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>75 YRS</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>July 20 1980</i>		2d. HOUR MIN <i>1200 PM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D. C.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>			
10. CITY OR TOWN OF DEATH <i>Tak Park</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash Adventist Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tailor</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Tailoring</i>			
13a. STATE <i>MD</i>										13b. CITY OR TOWN <i>PRINCE GEORGES</i>		13c. STREET ADDRESS <i>620 Sheridan St. #317</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Adolph Johnson</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rachel (Unknown)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>577-60-8272</i>				17. INFORMANT <i>Mrs. Betty Johnson</i>				ADDRESS <i>Same as No. 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hematoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Fractured Skull</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fell at Home</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i> <i>2 days</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>															
19a. DATE OF OPERATION <i>7-18-80</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Subdural Hematoma</i>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR P.M. <i>715 1980</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Fell down at home</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Sheridan St Chillum Prince Georges Md</i>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>John P. Regan</i>				TITLE (SPECIFY) <i>Dep. MEDICAL EXAMINER</i>										DATE SIGNED <i>July 20 1980</i>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>				23b. DATE <i>7/21/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Pr. Geo., Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Donald M. Stein</i>				HEBREW MEMORIAL F.H. <i>232 Carroll Street, N. W. Washington, D. C.</i>				25a. DATE REC'D. BY REGISTRAR (VSB. REG.) <i>JUL 25 1980</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 0 1 8 5 8 8		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT Edward JOHNSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7-28-80</b>		2b. HOUR <b>12-35<sup>PM</sup></b>	
3 SEX <b>MALE</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>70</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MARYLAND MontgomeryMD</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>coal miner</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph C. Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Hawkins</b>		16. STREET ADDRESS <b>1215 Edmonston Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>233 12 0822</b>		17. INFORMANT ADDRESS <b>E. Freeman Johnson 614 Monroe St. Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Circumstances of Pancreas</b> <b>1579</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>1</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/27/80</b> to <b>7/28/80</b> , that (I) (we) lost <b>above</b> the deceased alive on <b>7/27/80</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <b>Robert C. Macon M.D.</b>				22c. DATE SIGNED <b>7/28/80</b>		22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hardford Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>				25a. DATE REC'D BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert C. Macon</b>	
24. FUNERAL DIRECTOR ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>							

1928-29-30

Johnson

Robert

10 01 21

May

MARYLAND

BETTERMAN ZUBERMAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8018589			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADIE ELIZABETH JOHNSON						7 8 80						6 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR APR. 22, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.						13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3501 NORBECK Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST JASON PRATT						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE PRATT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 217-44-2785		17. INFORMANT ADDRESS Katherine Snowden 15524 Bailey Lane Silver Spring Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/18, 19 80 to 7/8, 19 80, that (I) (we) last saw the deceased alive on 7/7, 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M. C. Brace						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirkland C. Brace						22e. ADDRESS 1600 Carver Ave Takoma Park MD							
23a. BURIAL CREMATION, REMOVAL BURIAL				23b. DATE 7-12-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden						24b. ADDRESS 240 N. Wash. St. Rockville MD		25a. DATE REC'D. BY REGISTRAR JUL 11 1980		25b. REGISTRAR'S SIGNATURE [Signature]			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18590

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George W. Jones, SR.			2a. DATE OF DEATH MONTH DAY YEAR 7-20-80			2b. HOUR 10 <sup>00</sup> PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-6-1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH HAYENT. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SGT. PENNA-STATE POL.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11385 COLUMBIA PIKE	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA LANCE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
17. INFORMANT ADDRESS (SAME AS #13 ABOVE) MRS. KATHLEEN M. JONES		18. SOCIAL SECURITY NO. 195-32-4534							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. 10 yrs. 10 yrs.	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/17 1980, to 7/20 1980, that (I) (we) last saw the deceased alive on 7/18 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Keith M. Lindgren MD				DEGREE MD		22c. DATE SIGNED 7/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith M. Lindgren				22e. ADDRESS 7600 Carroll Ave Takoma Pk. Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/24/1980		23c. NAME OF CEMETERY OR CREMATORY MAPLE GROVE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ELIZABETHVILLE PENNA	
24. FUNERAL DIRECTOR NAME Arthur Waters		25a. DATE REC'D. BY REGISTRAR JUL 24 1980		25b. REGISTRAR'S SIGNATURE			

1191-3-8

2017



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Chang C. Kao</i>			2a DATE OF DEATH MONTH DAY YEAR <i>7-23-80</i>			2b HOUR <i>1:10 AM</i>			
3 SEX <i>Female</i>		4 RACE <i>Oriental</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>April 5, 1891</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>China</i>		7b CITIZEN OF WHAT COUNTRY? <i>China</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <i>Md.</i>		13b COUNTY <i>Frederick</i>		13c CITY OR TOWN <i>Frederick</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <i>Rt. # 2 Box 84</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>(Unknown) Chen</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>070-42-4257</i>		17 INFORMANT Address <i>Kensington, Md. 5004 Orleans Ct.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>7907 Bacteremia</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7/23/80</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>1976</i> , 19 <i>7/23/80</i> to <i>7/23/80</i> , that (I) (we) last saw the deceased alive on <i>7/22/80</i> , 19 <i>7/22/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>[Signature]</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>7/23/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. S. Adkins</i>			22e ADDRESS <i>2807 LEKATOL 745 Adelphi Rd Bethesda Md</i>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>Aug. 1, 1980</i>		23c NAME OF CEMETERY OR CREMATORY <i>Forest Lawn Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Hollywood Hills Calif.</i>		
24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A.</i>			ADDRESS <i>Bethesda, Md.</i>		25a DATE RECEIVED BY REGISTRAR <i>JUL 28 1980</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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OK - per Dr. Rogers (Carover)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

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101381080

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mildred B. Katz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY - 7 2 80</b>		2b. HOUR <b>12 19 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>707 Justin Way</b>		12a. USUAL OCCUPATION (TYPE USUAL FOR MOST OF WORKING LIFE) <b>LEGAL STENOGRAPHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN RED CROSS</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Berg</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rae Witofsky</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>104-16-5267</b>		17. INFORMANT ADDRESS <b>JACK L. KATZ, same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the Lung (3-80)</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7-2-80</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>June 12</b> , 19 <b>80</b> , to <b>JULY 2</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard W. Holt M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-2-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard W. Holt, M.D.</b>		22e. ADDRESS <b>3800 Reservoir Rd., N.W., Wash., D.C. 20007</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/6/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELMONT, LONG ISLAND, NEW YORK</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

18593

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CORA

LEE

KAUFMANN

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

Sep 18, 1929

6. AGE (IN YEARS)

50 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

2b. DATE KNOWN  
OF DEATHESTI-  
MATED

7-31 1980

2b. HOUR  
P.M.2c. DATE  
PRONOUNCED  
DEAD

Aug 1 1980

2d. HOUR  
4A.M.7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Chevy Chase

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

6665 Fairfax Road

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS  
OR INDUSTRY

-----

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Chevy Chase

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

6665 Fairfax Road

14. FATHER'S NAME

Cecil

David

Kaufmann

15. MOTHER'S MAIDEN NAME

Isabelle

MIDDLE

Grotta

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

-----

17. INFORMANT

056-26-9848

11300 Rockville Pike, Rockville, Md.

Harvey A. Jacobs, Atty.

Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

9506  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Self-induced.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

John S. Ball

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE  
SIGNED

Aug 1, 1980

EXAMINER'S NAME  
(TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

8-3-80

23c. NAME OF CEMETERY OR CREMATORY

Wash. Heb. Cong. Cem. Washington, D.C.

23d. LOCATION  
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME

ADDRESS

Rockville, Md.

25a. DATE RECEIVED BY REGISTRAR

AUG 5 1980

25b. REGISTRAR'S SIGNATURE

Danzansky-Goldberg Chapels; 1170 Rockville Pike



1881 2300




 1- FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

 80 18594  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BARBARA kekeris</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-22-80</b>			2b. HOUR <b>10:10AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 6, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Mehopoulos</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleftheria Unknown</b>		16. SOCIAL SECURITY NO.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>daughter Mary K. Alexander</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Left Ventricular Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic cardiomyopathy</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Left Ventricular Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic cardiomyopathy</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>March 19, 1980</b> , to <b>22 July 1980</b> , that (I) (we) lost saw the deceased alive on <b>22 July 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Gustavo S. Belaval</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>22 July 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GUSTAVO S. BELAVAL</b>				22e. ADDRESS <b>Leisure world Medical Center Silver Spring, Md 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul. 24, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Ph. Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins 500 University Boulevard, W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby McLeod</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Floyd E Kemerer			2a DATE OF DEATH MONTH DAY YEAR 7 11 80		2b HOUR 9 09 P M	
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 12 11 19	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY Auto's	
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spring	
14 FATHER'S NAME FIRST MIDDLE LAST Elmer W. Kemerer			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Donnal			
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 577-26-3401		17 INFORMANT (wife) ADDRESS Vivian M. Kemerer- (same as 13e)		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

410 -  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 70, to 7-11 19 80, that (I) (we) last saw the deceased alive on 7-11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It was (did) (did not) view the body after death.)			
22b SIGNATURE D.C. Bucy	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7-11-80
22d PHYSICIAN'S NAME (TYPE OR PRINT) D.C. Bucy	22e ADDRESS 809 Veas Mill Rd		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 7-14-1980	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d LOCATION CITY OR TOWN COUNTY STATE Sil. Spring Montgomery Md.
24 FUNERAL HOME NAME E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25 DATE REC'D. BY REGISTRAR JUL 16 1980	25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) George Clarence KENT			2a DATE OF DEATH MONTH DAY YEAR July 14 1980			2b HOUR 1117A M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Feb. 5 1923		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b KIND OF BUSINESS OR INDUSTRY Public Health Service			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Pr. George		13c CITY OR TOWN Laurel		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Jonathan Morris Kent			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Viola Baker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Mrs. Ruth F. Kent See above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic prostatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>July 14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>L H FINK, M.D.</u>						22c DATE SIGNED July 14, 1980			
22d PHYSICIAN'S NAME (TYPE OR PRINT) L H FINK, M.D.						22e ADDRESS National Naval Medical Center, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 7/17/80		23c NAME OF CEMETERY OR CREMATORY Union Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.		
24 FUNERAL DIRECTOR NAME Fleck Funeral Home			7601 Sandy Spring Rd. Laurel, Maryland		75a DATE REC'D. BY REGISTRAR JUL 17 1980		75b REGISTRAR'S SIGNATURE <u>Ruth F. Kent</u>		

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

0 9 1 0 8

W. H. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FENTON Jerome Kephart			2a. DATE OF DEATH MONTH DAY YEAR July 12, 1980			2b. HOUR 9:32 AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 6 1915		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coin Laundry Oper.		12b. KIND OF BUSINESS OR INDUSTRY Laundrymat		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 25 Walker Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST George Marion Kephart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Miriam Belt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 577-05-1972		17. INFORMANT ADDRESS 505 Diane Drive, Fenton Jerome Kephart, Jr. W. Chester, Pa.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN PRIMARY DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/14, 1980, to 7/12, 1980, that (I) (we) last saw the deceased alive on 7/11, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Kirkland C. Bruce			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/12/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND C. BRUCE			22e. ADDRESS 1600 Carroll Ave Takoma Park							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/15/80		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg, Md.				
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H.			316 E. Diamond Ave., Gaithersburg, Md.			25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 5 9 8  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Janet Kirkpatrick</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-19-80</b>		2b. HOUR M <b>4a</b>
3. SEX <b>F</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 6 92</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>
13a. STATE <b>D.C. Md</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Washington</b>	13e. STREET ADDRESS <b>1301 15th St. N.W. Rd</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Kirkpatrick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Taggart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-50052</b>		17. INFORMANT NAME ADDRESS <b>Janet Arnold - above</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiac anhylinias</b> (c) <b>systemic hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (we) (this hospital) attended the deceased from <b>1978</b> , 19____, to <b>7/18</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/01</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DR. JOSEPH M. SOLINAS FOR DR. KENTON</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH SOLINAS</b>		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 22, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Granite Presbyterian</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Granite Md</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Daniel Dan Funeral Home Laurel</b>		25a. DATE REC'D. BY REGISTRAR <b>Aug 25 1980</b>	25b. REGISTRAR'S SIGNATURE <b>Hester</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHHM-16 25M  
(VRA 15, 4) 1/79STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 5 9 9

REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ABE F. KIRSCHBAUM		2a. DATE OF DEATH MONTH DAY YEAR 7 16 80		2b. HOUR 5:45 AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JUNE 22, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA HEALTH CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUDITOR		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC KIRSCHBAUM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH (UNASCERTAINABLE)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW I		16b. SOCIAL SECURITY NO 111-07-7003A	
17 INFORMANT ADDRESS FRANCES KIRSCHBAUM, same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> 19 <u>78</u> to <u>7-16</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
27b. SIGNATURE <u>Dr. Jason Geiger</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 7-16-80	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JASON GEIGER, M.D.		27e. ADDRESS 8830 CAMERON STREET, SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/17/1980		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI, PR. GEORGES, MD.	
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.		25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE <u>Barry McCreedy</u>			

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NEW YORK U.S.A. WHITE 1234 56 789  
BETHESDA MONTGOMERY SILVER SPRING 1234 56 789  
KIRSCHEIDT 111-07-70024  
FRANCIS KIRSCHEIDT, JR. 111-07-70024  
[UNASCERTAINABLE]

NEW YORK U.S.A. WHITE 1234 56 789  
BETHESDA MONTGOMERY SILVER SPRING 1234 56 789  
KIRSCHEIDT 111-07-70024  
FRANCIS KIRSCHEIDT, JR. 111-07-70024  
[UNASCERTAINABLE]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 0 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELEANOR Ruth KNEESSI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 4 80</b>		2b. HOUR <b>8:38A M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>10 12 97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD		10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Adelphi</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Daniel O. Drennan</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Frances Merrill</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>578-46-4859</b>		17 INFORMANT <b>niece Evelyn E. Leaman same as 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>4140- VENTRICULAR FIBRILLATION</b> <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c). <b>General atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>10 or more years</b> <b>YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>SYSTOLIC HYPERTENSION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>JAN 56</b> to <b>JULY 4 1980</b> , that (1) (we) last saw the deceased alive on <b>JULY 4 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James A. Roberts, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>JULY 4, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. ROBERTS</b>		22e. ADDRESS <b>8907 GEORGIA AVE. SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins</b> <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 11 1980</b> <b>Robert A. Roberts</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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*[Faint, mostly illegible text and markings covering the central portion of the page, possibly bleed-through from the reverse side.]*

*[Faint text at the bottom of the page, including what appears to be a signature or name on the left and some printed text on the right.]*

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 0 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Karl J KOOPS</u>			2a DATE OF DEATH MONTH DAY YEAR <u>July 17 1980</u>			2b HOUR <u>1:27 PM</u>			
3 SEX <u>MALE</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>4/19/16</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>64</u> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW JERSEY</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.			
10 CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SALES REP</u>		12b KIND OF BUSINESS OR INDUSTRY <u>VERNON McMILLAN INC</u>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN <u>MARYLAND</u> <u>PRI. GEORGES</u> <u>HYATTSVILLE</u>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <u>2107 LEWISDALE DRIVE</u>		
14 FATHER'S NAME FIRST MIDDLE LAST <u>LOUIS KOOPS</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ALMA SCHUMACHER</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW II</u>		17 INFORMANT <u>JUNE E. KOOPS</u>		ADDRESS <u>SAME AS 13</u>		WIFE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the esophagus</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxemic brain damage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>probable opportunistic lung infection</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>hours</u> <u>2 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>7/17</u> <u>1980</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>7/17</u> 19 <u>80</u> to <u>7/17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) touch the body after death.									
22b SIGNATURE <u>FOR DR. G. LEHMAN</u> DEGREE <u>GOLD</u> <u>EDWARD S. MEHLMAN</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <u>7/17/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWARD S. MEHLMAN</u>						22e ADDRESS <u>SILVER SPRING, MARYLAND</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b DATE <u>7/21/80</u>		23c NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>WESTFIELD UNION NEW JERSEY</u>		
24 FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>						25a DATE RECEIVED BY REGISTRAR <u>JUL 21 1980</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 6 0 2	
1 - FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond Lee KOSACK					2a. DATE OF DEATH MONTH DAY YEAR July 3 1980			2b. HOUR 3:55P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 24 1958		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS Route 1, Box 93				
13a. STATE Pennsylvania		13b. COUNTY Schuylkill		13c. CITY OR TOWN Pine Grove							
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kosack				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Mary Herring							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1975-80		17. INFORMANT ADDRESS Josephine Mary Kosack see item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NEUROPATHY OF UNKNOWN ORIGIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>Apr. 15</u> , 19 <u>80</u> , to <u>July 3</u> , 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>July 3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. Stephen Bohan</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. STEPHEN BOHAN</u>						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 7, 1980		23c. NAME OF CEMETERY OR CREMATORY St. Johns U C C		23d. LOCATION CITY OR TOWN COUNTY STATE Freidensburg, Schuylkill, Pa.					
24. FUNERAL DIRECTOR NAME W. W. Chambers Co.						ADDRESS Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUL 9 1980			
						25b. REGISTRAR'S SIGNATURE <u>History/Hubert</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 6 0 3	
FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nicholas (nmn) Kosmas</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 7, 1980</b>			2b. HOUR <b>10:11P</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 7, 1970</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>10</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>10 11</b>		IF UNDER 24 HRS HOURS MIN. <b>10 11</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Greece</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, NIH, Beth.Md</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Greece</b>					13b. COUNTY		13c. CITY OR TOWN <b>Arta</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodosia Kosmas</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Athanasios Lambrou</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>N/A</b>		17 INFORMANT ADDRESS <b>Add. same</b> <b>Mr. Theodosia Kosmas (father) as Patient</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcal Sepsis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
570- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive Hepatic Ischemic Necrosis</b>										<b>4 Days</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Renal Failure</b>										<b>2 Days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Cardiomyopathy of Unknown Etiology</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>June 25</b> , 19 <b>80</b> , to <b>July 7</b> , 19 <b>80</b> , that (we) lost saw the deceased alive on <b>July 7</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Karl J. Karlson</b>								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8 July 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KARL J. KARLSON</b>								22e. ADDRESS <b>National Institutes Of Health Clinical Center, Bethesda, Md 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>7/11/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arta Greece</b>			
24 FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md</b>								25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>R. J. Brady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 8 6 0 4		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Jean Kossarides		FIRST M. MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR July 23, 1980		2b HOUR 12:18am	
3 SEX male Male		4 RACE white Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 55 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant		12b. KIND OF BUSINESS OR INDUSTRY marketing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Jean Kossarides		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Draper		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII			
16b SOCIAL SECURITY NO. 156-16-8170		17 INFORMANT June Kossarides		18 ADDRESS 21 Meadowcroft Court Gaithersburg, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Liver failure							
DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Carcinoma							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Azotemia							
19a DATE OF OPERATION 6/18/79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Total Gastrectomy (Gastric Carcinoma)		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from April 3, 1980, to July 23, 1980, that (we) lost saw the deceased alive on July 22, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Aaron Kirkemo		DEGREE MD		22c DATE SIGNED 7/23/80		22d ADDRESS 5900 Conway Rd Bethesda MD 20034	
22e PHYSICIAN'S NAME (TYPE OR PRINT) Aaron Kirkemo MD		22f ADDRESS 5900 Conway Rd Bethesda MD 20034		22g DATE REC'D. BY REGISTRAR JUL 29 1980			
22h REGISTRAR'S SIGNATURE Pietro M. Brady		22i DATE REC'D. BY REGISTRAR JUL 29 1980		22j REGISTRAR'S SIGNATURE Pietro M. Brady			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE July 24, 1980		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION CITY OR TOWN COUNTY Suitland, Prince Georges, Md.	
24 FUNERAL DIRECTOR 5130 Wisconsin Avenue, N. W. Washington, D. C. 20016		24a DATE REC'D. BY REGISTRAR JUL 29 1980		24b REGISTRAR'S SIGNATURE Pietro M. Brady		24c DATE REC'D. BY REGISTRAR JUL 29 1980	

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Adele Ketchum KREITZER			2a. DATE OF DEATH MONTH DAY YEAR July 16 1980			2b. HOUR 6:30A M					
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 2 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Dept. store			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Harwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 154 Pollinghouse Road			
14. FATHER'S NAME FIRST MIDDLE LAST William A. mos Ketchum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Exley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 216 30 5510		17. INFORMANT ADDRESS James F. Kreitzer See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of right lung with metastases 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 8 1980, to July 16 1980, that (I) (we) last saw the deceased alive on July 16 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Small LT MC USA				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 17 July 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. S. SMALL				22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7-18-80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md.			
24. FUNERAL DIRECTOR NAME Hicks Funeral Home				C. E. HICKS 111 Address Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ADRIEN Edmond LAURENCELLA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 30, 1980</b>			2b. HOUR <b>6:05 P</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 13, 1896</b>		6. AGE (YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Project Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. of State</b>			
13a. STATE <b>D.C.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>2122 Massachusetts Avenue, N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Alphonse Laurencelle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Gingras</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO <b>087-03-0833</b>	
17. INFORMANT <b>daughter</b>			ADDRESS <b>6512 North Newgard Av</b>			17b. <b>Dr. Patricia Laurencelle Chicago, Ill.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEPATIC CRISIS</b> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATOMA (LIVER)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <b>SENILITY</b> 131AR								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SENILITY</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 7/23 1980</b> to <b>7/30 1980</b> , that (1) (we) lost saw the deceased alive on <b>7/23 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>Thos G. Ward</b>			22c. DATE SIGNED <b>7/31/80</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>			22f. ADDRESS <b>616 ROBINWOOD, BETHESDA, MD 20814</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug 4 1980</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Kings N.Y.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Robert McLeod</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Edmund

Feb. 12, 1894

University

USA

New York

U.S.

Edmund Wilson, Jr. 1125 Massachusetts Avenue, N.W.

Washington, D.C.

Alphonse Laumond  
657-12-1225 Dr. Patricia Laumond, Chicago, Ill.  
Chicago, Ill.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18607	
1. DECEASED NAME (TYPE OR PRINT) <b>Orion J. Lawrence</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>July 24 1980</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 26 1898</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>81</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>July 24 1980</b>		2b. HOUR <b>8:21</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Est. Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SCHOOL TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Est. Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7804 CARROLL AVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAWRENCE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NOT AVAILABLE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-07-4183A</b>		17. INFORMANT ADDRESS <b>IRA W. LAWRENCE, LORTON, VA</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John D. Egan</b>				TITLE (SPECIFY) <b>MD</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				DATE SIGNED <b>July 24 1980</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 29, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore P.D. MD</b>			
24. FUNERAL DIRECTOR <b>William Waters</b>		25a. DATE REC'D. BY REGISTRAR <b>July 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>MA</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 8 6 0 8		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST CAROLYN		MIDDLE O.		LAST LEASURE		2a. DATE OF DEATH		MONTH DAY YEAR	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. MONTH		7b. HOUR	
Female		White		Mar. 14 1907		73 YRS.		24		6:45 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Arkansas		U.S.A.				Montgomery MD.		Kensington		10225 Kensington Pkwy.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
12a. Home		12b. Homemaker		12c. Home		Md.		Montgomery		Kensington	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
James		Pearl		No		579-68-4555		Son		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1490		Metastatic Carcinoma		Carcinoma of Throat							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. DATE OF OPERATION		21b. TIME OF INJURY	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION		21f. LOCATION		21g. LOCATION		21h. LOCATION	
22a. I certify that (I) (this hospital) attended the deceased from		22b. DATE		22c. DATE SIGNED		22d. DATE SIGNED		22e. DATE SIGNED		22f. DATE SIGNED	
19. 68. to July 24 19. 80. that (I) (we) last saw the deceased alive on July 20 19. 80. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		7/26/1980		7/24/80		7/24/80		7/24/80		7/24/80	
22g. SIGNATURE		22h. ADDRESS		22i. ADDRESS		22j. ADDRESS		22k. ADDRESS		22l. ADDRESS	
John B. Umbau MD		5805 Conn. Ave. Chevy Chase Md. 20015									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION		23f. LOCATION	
Burial		7/26/1980		Holy Rood Cemetery		Washington, D.C.		Washington, D.C.		Washington, D.C.	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS		24e. ADDRESS	
Joseph Gawler's Sons Inc.		5130 Wisc. Ave., N.W.		Washington, D.D.							
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE		25f. REGISTRAR'S SIGNATURE	
JUL 29 1980		JUL 29 1980		JUL 29 1980		JUL 29 1980		JUL 29 1980		JUL 29 1980	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner Notified and Approved

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 1 8 6 0 9			
1. DECEASED NAME (TYPE OR PRINT) <b>SHER W. LEE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 5, 1980</b>				2b. HOUR <b>5:10 AM</b>			
3. SEX <b>M</b>		4. RACE <b>Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 01 68</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canton, China</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Owner-Grocery Store</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>WHEATON</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2611 CORY TERR</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lee Hawk Din</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lok Shee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-46-9292</b>		17. INFORMANT ADDRESS <b>Spring, Md. 20906</b> <b>David Lee (son) 2428-East Gate Dr., Silver</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROTIC</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEART DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>10 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 25, 1980</b> , to <b>JULY 4, 1980</b> , that (I) (we) saw the deceased alive on <b>MAY 25, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Henry Stout</b> DEGREE <b>MD</b>								22c. DATE SIGNED <b>7/5/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. W. STOUT</b>								22e. ADDRESS <b>10829- GEORGIA AVE., WHEATON, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 13, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Wash. Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Adelphi, Maryland</b>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>J. Wm. Lee's Sons Co.</b> ADDRESS <b>300-4th St., NE, Wash., DC 20002</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

95-0-1011-51-1

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>SAMUEL NNN LESSANS</i>		2a DATE OF DEATH MONTH DAY YEAR <i>July 18, 1980</i>		2b HOUR 9 <sup>45</sup> AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 9 3 99		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b CITIZEN OF WHAT COUNTRY? USA - Naturalized	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical		12b KIND OF BUSINESS OR INDUSTRY Supply
13a STATE Md.		13b COUNTY Mont	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Max Lessans		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam Marder			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-9919		17 INFORMANT ADDRESS	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 2396 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Brain Stem Tumor</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 mins</i> <i>about 6 months</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Systemic Lupus Erythematosus</i>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) [this hospital] attended the deceased from <i>3/12</i> 19 <i>54</i> , to <i>7/18</i> 19 <i>80</i> , that (1) <del>(the)</del> last saw the deceased alive on <i>7/17</i> 19 <i>80</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(was)</del> (d-d) <del>(died)</del> view the body after death.			
22b SIGNATURE <i>Benjamin Dracov, MD</i>		22c. DATE SIGNED 7/18/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 7733 ALASKA Ave N.W. Wash. DC 20012	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 7/21/80	23c. NAME OF CEMETERY OR CREMATORY	
24 FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR JUL 25 1980	
ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE <i>Patrick McCreedy</i>	

11/1/58

TO: SAC, ALBUQUERQUE  
FROM: SAC, DENVER  
SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 8 6 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ana R. Lopezano</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7 30 80</b>			
3. SEX <b>Female</b>		4. RACE <b>Cuban</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 30 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cuba</b>		7a. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Gaithersburg Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Heuman Ym. Wilson Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Heumantown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jose Cachinero</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luz Agumonte</b>		13e. STREET ADDRESS <b>11424 Sceney Place</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213 82 1091</b>		17. INFORMANT <b>Jesus Lopezano</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>1901</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>metastatic orbital carcinoma</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/80</b> 19 <b>80</b> , to <b>7/30/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael Bolognese</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/30/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Michael Bolognese</b>				22e. ADDRESS <b>19261 Montgomery Village Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/1/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler</b>				ADDRESS <b>1331 Rockville Pike</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>Lutney McBratney</b>			

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16

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 6 1 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elda P. Linch			2a. DATE OF DEATH MONTH DAY YEAR July 7, 1980			2b. HOUR 6:35 PM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8903 Ewing Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Winfield Scott Shore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kincaid						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-26-60994		17 INFORMANT Eleanore Wilson Same As Item #13			ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular failure.</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Anterior Disease.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arteriosclerosis.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Diabetes Mellitus</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 2, 1980</i> to <i>present</i> , that (I) (we) last saw the deceased alive on <i>July 2, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <i>view the body after death.</i>									
22b. SIGNATURE <i>Donald Q. Ekman</i>			DEGREE MD			22c. DATE SIGNED 7/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Q. Ekman M.D., P.A.			22e. ADDRESS 4720 Chevy Chase Drive, Ch.Ch.Md. 20015						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-10-80		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR JUL 15 1980						
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 1 8 6 1 3  
REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>RACHEL</u> MIDDLE LAST <u>LOBEL</u>		2a. DATE OF DEATH MONTH <u>7</u> DAY <u>23</u> YEAR <u>80</u>		2b. HOUR <u>1:18</u> AM	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH <u>JUNE</u> DAY <u>20</u> YEAR <u>1897</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ISRAEL</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS	
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HEBREW HOME OF GREATER WASHINGTON</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co. MD.</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>KENNINGTON</u>	
14. FATHER'S NAME FIRST <u>JECHESKAL</u> MIDDLE LAST <u>SIMONOWITZ</u>		15. MOTHER'S MAIDEN NAME FIRST <u>RIFKA</u> MIDDLE LAST <u>COHEN</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219-14-0627A</u>		17. INFORMANT ADDRESS <u>REBECCA BESTIMT, 10801 MIDSUMMER DRIVE, RESTON, VIRGINIA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>4821</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PSEUDOMONAS AERUGINOSA</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>SEVERE SENILE DEMENTIA</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SEVERE SENILE DEMENTIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/10/78</u> to <u>7/23/80</u> , that (I) (we) lost saw the deceased alive on <u>7/23/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>7/23/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D.D. PATEL</u>		22e. ADDRESS <u>6121 MONTROSE RD. ROCKVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>7/25/1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CONGREGATION CEMETERY</u>	
24. FUNERAL DIRECTOR <u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>HILLSIDE, PR. GEO. MARYLAND</u>		23e. DATE REC'D. BY REGISTRAR <u>JUL 26 1980</u>	
23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WPA-1942  
JANUARY 1942

RECEIVED  
JAN 19 1942

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

NO. 8

1942-1943

1942-1943





FOR  
1 - STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 6 1 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Hobert				Longmire	July 5, 1980				12:05P
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	MONTH DAY YEAR Sept. 7, 1896			83	MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Tenn.	U.S.A.				Montgomery MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney	Montgomery General Hospital				Carpenter		Building		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md.		Carroll	Woodbine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7658 Woodbine Rd.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		(IF YES, GIVE WAR OR DATES)					
FRANK		Belle		No					
16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
401 01 4395		Ruth Ridgley		Woodbine, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									1 minute
DUE TO, OR AS A CONSEQUENCE OF									1 wk.
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									Years
(c) Chronic obstructive pulmonary disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Old myocardial infarction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
22a. I certify that (1) (this hospital) attended the deceased from 7/5 to 7/5, 1980, that (1) (was) lost									
saw the deceased alive on 7/5, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated									
above, (1) (was) (did) (not) observe the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Charles H. Ligon, M.D.						7/5/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECEIVED BY REGISTRAR					
		1811 Prince Philip Drive		JUL 15 1980					
		Olney, MD 20832		22g. REGISTRAR'S SIGNATURE					
				M. J. McHenry					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		7-8-80		Cresthaven Cemetery		Marriottsville		Howard Md.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		29. DATE RECEIVED BY REGISTRAR			
Harry W. Haight		Lynchville, Md.				JUL 15 1980			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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*[Faint, illegible handwritten text covering the majority of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Simon G. Ludwig			2a. DATE OF DEATH MONTH DAY YEAR July 29, 1980			2b. HOUR a 11:50 AM			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Machinist		12b. KIND OF BUSINESS OR INDUSTRY Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2 McKay Circle	
14 FATHER'S NAME FIRST MIDDLE LAST James G. Ludwig				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Bowman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 277-03-3404		17 INFORMANT ADDRESS Blva P. Ludwig (Wife) Same as #13e					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> 4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b) <i>ventricular fibrillation</i> (c) <i>on electrocuted heart disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 min. 6 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>chronic obstructive pulmonary disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Sept 1956, to 29 July 1980, that (I) (we) lost saw the deceased alive on 29 July 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE MD				22c. DATE SIGNED 7/29/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. WYMAN MD.				22e. ADDRESS 7501 NEW FILL AVE Bethesda MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 1, 1980		23c. NAME OF CEMETERY OR CREMATORY Sperry Run U.M.C. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rte, West Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service Fairfax, Va.				25a. DATE REC'D. BY REGISTRAR AUG 18 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

75

Feb. 2, 1953

100

John V. Smith

William J. Smith

John V. Smith

William J. Smith

John V. Smith

William J. Smith

John V. Smith

William J. Smith

John V. Smith

William J. Smith

John V. Smith

217-02-3400 (111) same as 110

100

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 6 1 6

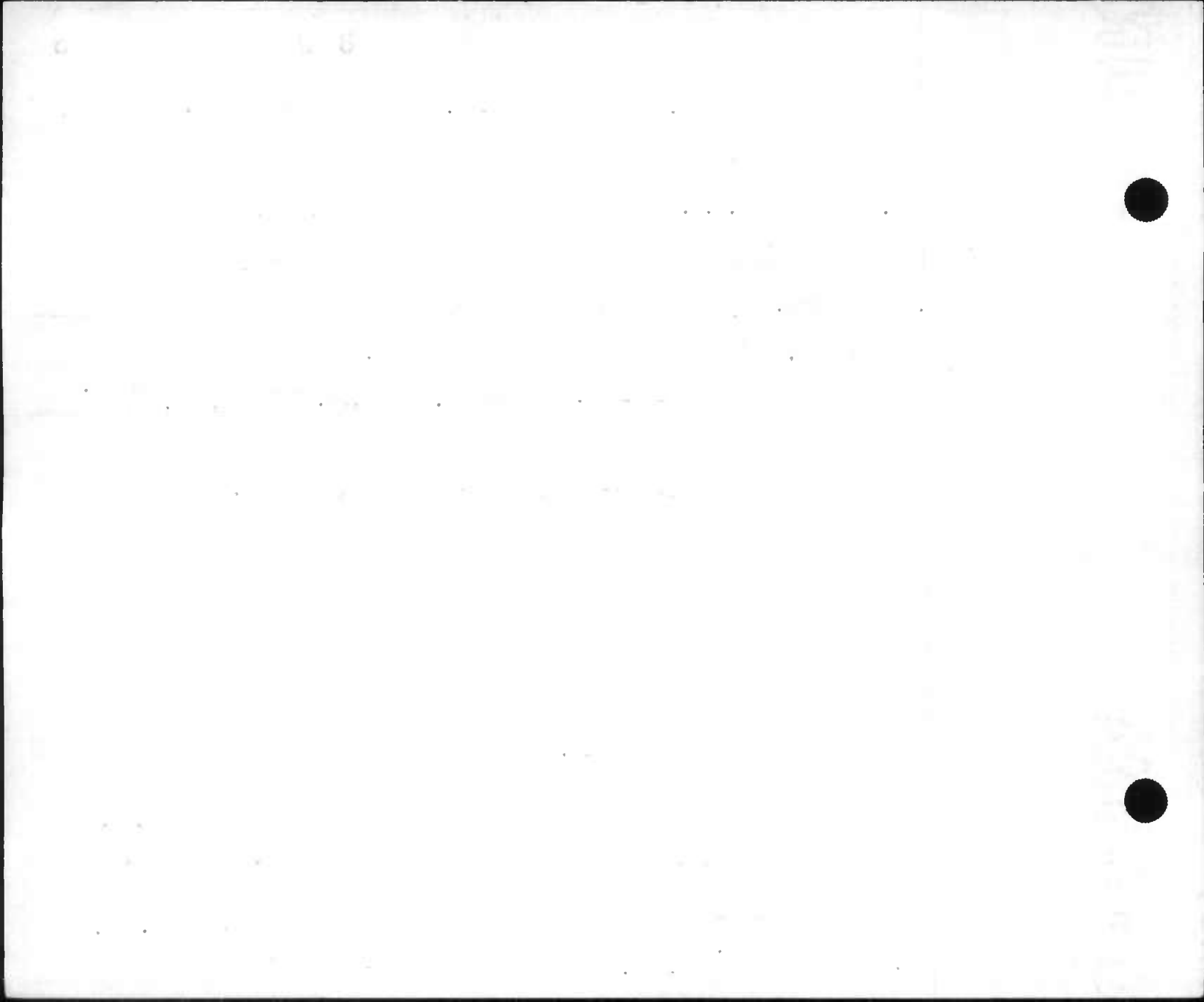
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard B. LYLES, SR.			2a. DATE OF DEATH MONTH DAY YEAR July 18.80			2b. HOUR 4:20 M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 25 18		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Poolesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19415 Jerusalem Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Lyles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary F. Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 577-14-6019	
17. INFORMANT ADDRESS 11215 Coppermine Rd. Woodboro, Md. 21798							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185- DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis due to prostate, primary. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Lymphangitic spread both lungs, liver metastasis, bone metastasis.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 22. 19 79 to 18 July 19 80, that (I) (we) last saw the deceased alive on early July 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Donald E. Dillon		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7.18.80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E DILLON, M.D.		22e. ADDRESS 18111 Prince Philip Dr. OLNEY, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-22-80		23c. NAME OF CEMETERY OR CREMATORY Elijah Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Poolesville, Montg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		246 N. Washington Street Rockville, Md. 20850		25a. DATE RECD. BY REGISTRAR JUL 21 1980		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 20M  
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18617									
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND C. MACKEY										MONTH DAY YEAR 7-4-80		19 12:00 PM							
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH (MONTH DAY YEAR) Dec. 20, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD July 4, 1980		2d. HOUR 12:00 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.									
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor, Veterinary Medicine				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. CITY OR TOWN		13b. STREET ADDRESS							
13a. STATE Maryland										13b. CITY OR TOWN Montgomery		13c. STREET ADDRESS 6668 Hillandale Road							
14. FATHER'S NAME FIRST MIDDLE LAST George Raymond Mackey										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian Wietrick									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 376-28-1308		17. INFORMANT ADDRESS Deborah Boone Mackey, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drug Overdose. Barbituate.</u> 9501 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Self-Inflicted</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 9:50 P.M. 7-3 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Injected. Barbituate - intravenous.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5110 Narmakegan Rd Bethesda Montgomery, Md											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. DePutg				DATE SIGNED July 4, 1980											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Road Bethesda, Maryland 20014															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7/6/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia									
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 14 1980											
								25b. REGISTRAR'S SIGNATURE R. J. McCreedy											

4802





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 1 8

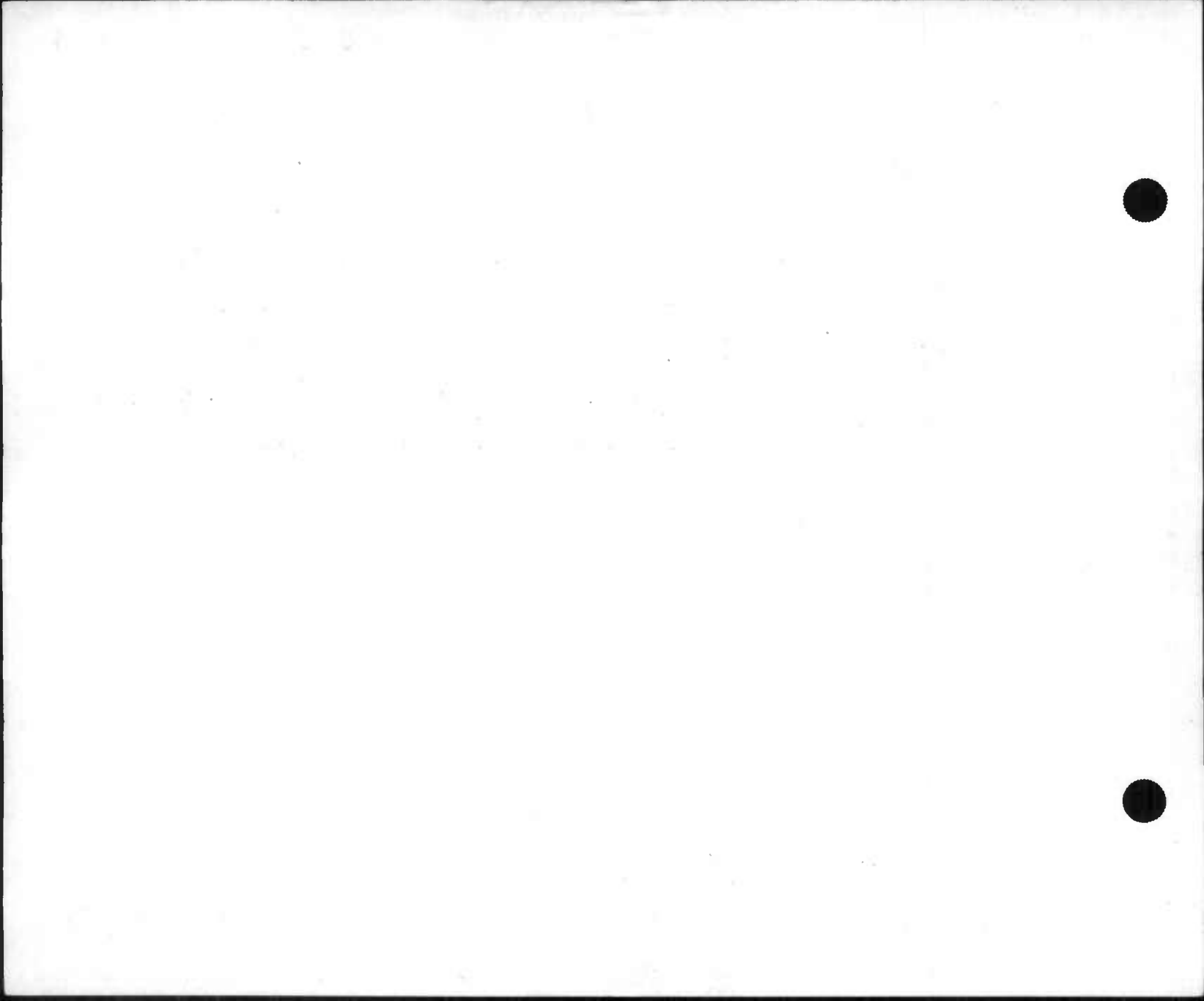
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME FIRST MIDDLE LAST Ada MANNING		7 15 80		4 20 AM	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 6 25 96		6 AGE (IN YEARS LAST BIRTHDAY) 84	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b CITIZEN OF WHAT COUNTRY? U.S.		8 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME	
13a STATE MD		13b COUNTY MD		13c CITY OR TOWN WHEATON	
14 FATHER'S NAME HERBERT		15. MOTHER'S MAIDEN NAME Link		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO 037200423		17 INFORMANT DOROTHY LITTLE		18 ADDRESS 1111 BRICE DR EDGEWATER, MD.	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1749 Carcinoma of Breast with metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/10 to 7/15 1980, that (I) (we) last saw the deceased alive on 7/15 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b SIGNATURE Myron L. Lenkin		DEGREE MD		22c DATE SIGNED 7/18/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/18/80		23c NAME OF CEMETERY OR CREMATORY LAKEHURST	
24 FUNERAL DIRECTOR NAME John M. Taylor Sons Funeral Home		ADDRESS BALTIMORE MD		25a REG. CL. BY REGISTRAR 25b REGISTRAR'S SIGNATURE JUL 18 1980	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

Item 18c G547 9/4/80 dad

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 1 9

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marta <del>XXXXXXXXXX</del> Martin			2a DATE OF DEATH MONTH DAY YEAR July 21, 1980			2b HOUR 4:50 PM	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 8 14 89		6 AGE IN YEARS LAST BIRTHDAY 90 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Tk. Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Giuseppe Troian		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Valentina Martin		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) -----			
16b SOCIAL SECURITY NO. -----		17 INFORMANT Iva Trentelman- dau- (same as 13c)		18 ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 5579 IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Peritonitis DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic colitis (colectomy) Enteric anastomotic breakdown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12-14 hrs 23 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Stomach Intake p.o. Transverse Colectomy - Lap. enterostomy							
19a DATE OF OPERATION 7/21/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis & part. intestine		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 7/21 1980, to 7/21 1980, that (1) (we) last saw the deceased alive on 7/21 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marta Troian		DEGREE		22c. DATE SIGNED 7-22-80		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M. Eichler		22f. ADDRESS 3915 Ferrara Dr. Wheaton 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-24-80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25. DATE OF RECORD BY REGISTRAR AUG 6 1980					

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **8 0 1 8 6 2 0**

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Samuel</b>		FIRST MIDDLE LAST <b>Mc Call</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 25 19 80</b>		2b. HOUR <b>10:50 AM</b>	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 3, 1926</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>53 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 26 19 80</b>	2d. HOUR <b>10:50 AM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Laytonsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7500 Brink Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Laytonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7500 Brink Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Claudie McCall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Buchanan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1945-1946</b>		17. INFORMANT <b>Pearl Prince</b>		ADDRESS <b>4822 Alabama Ave. S.E. Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Hypertensive cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>4039</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>J.R. Snowden</b>				TITLE (SPECIFY) <b>Assistant</b>		M.D. _____		DATE SIGNED <b>7/27/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-30-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>				ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Summit

Dec. 2, 1950

U.S.A.

7-10-1950

Lavtonsville

Claudio McGarr

Lucy Buchanan

Yes 1945-1946

550-3-1222

Pearl Prince

4022 Algonquin Ave. S.E.  
Washington, D.C.

U.S. National Archives

CONFIDENTIAL

202-0110

Actual

Algonquin Park

Dec. 2, 1950

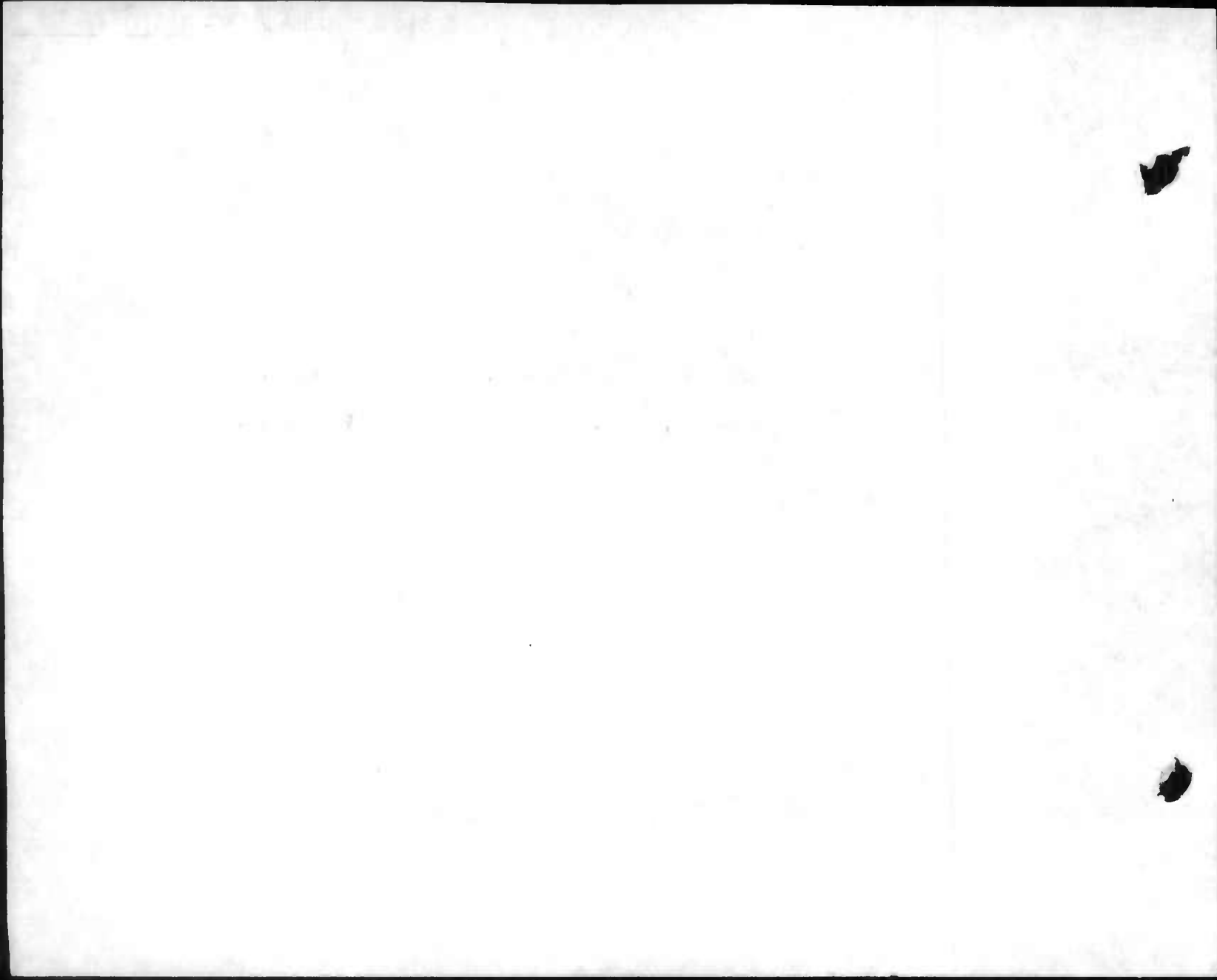
Dec. 2, 1950

*Handwritten signature*

VOIDED DEATH CERTIFICATE NUMBER LISTED ABOVE

SEE: ROBERT RAY MCCANN, MONTGOMERY COUNTY,

MARCH 19, 1979. FILED WITH LATE 1979 DEATHS.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 6 2 2

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert A. McConnell, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 27, 1980</b>		2b. HOUR <b>3:28A</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 21, 1924</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Optician</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Optical Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>	13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2215 Amherst Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert A. McConnell, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther Taylor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>	17. INFORMANT ADDRESS <b>Ruth A. McConnell, Same as #13</b>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>Immediate</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, this hospital) attended the deceased from <b>Aug 1 1976</b> to <b>27 Jul 80</b> , that (I, we) last saw the deceased alive on <b>27 Jul 80</b> and that in (my, our) opinion death occurred on the date and hour and from the causes stated above (I, we) (we) (we) could not view the body after death.					
22b. SIGNATURE <b>Alan I. Kermaier, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>29 Jul 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN I. KERMAIER, MD</b>		22e. ADDRESS <b>9801 Georgia Ave. S.S. Md 2080</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>7/30/1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Esther Taylor</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (S))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		8018623	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Barbara Joyce Mc Cord		MONTH DAY YEAR 7 30 19 80	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
female	white	Aug. 12, 1958	21 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
Takoma Park, Md.	United States	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	Montgomery County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Springs	12001 Old Columbia Pike	Waitress	Raleigh Inn
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
Laps David McCord	Loretta Olson	1107-Kathryn Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	
No	219-72-1509	Ave, Silver Spring, Md. 20902 Patricia A. Kreitlow (Sister) 10707-Amherst	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:			
9654 IMMEDIATE CAUSE (a) Gun shot wound of head			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XX 7/ 30 1980	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house	21f. LOCATION CITY OR TOWN Silver Springs 12001 Old Columbia Pike, Mont Co, MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
Hormez R. Guard	Assistant	7/31/80	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Hormez R. Guard, M.D.	111 Penn Street, Balto, MD 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Aug. 2, 1980	Washington National Cem.	Suitland, Maryland
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002	AUG 5 1980		



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United States

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## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018624	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Earl Randolph McCoy</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>7-19-80</b>		2b. HOUR <b>2:50A</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-17-27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. <b>XX</b> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Acetylene Operator Air Products</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>P.G.</b> 13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3582 Powder Mill Rd, #203</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Albert McCoy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lora Patzel</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>227-34-4077</b>		17. INFORMANT <b>Gloria D. McCoy</b>		ADDRESS <b>Address: Same as No# 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>pulmonary edema, shock, arrest</b> <b>3h</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>probable acute myocardial infarction</b> <b>3h</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic heart disease</b> <b>710yrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <b>19 July</b> , 19 <b>80</b> , to <b>17 July</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>19 July</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22a. SIGNATURE <b>Dennis J. Donohue</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>21 July 80</b>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dennis J. Donohue MD</b>				22e. ADDRESS <b>7600 Carroll Ave Takoma Park, Md. 20012</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-22-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville P.G. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Forney McCreedy</b>					



Item 16b G 547 9/26/80 GB

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jerome S. McKay Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 28, 1980</b>		2b. HOUR <b>5:55PM</b> M					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 12 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Agent of Amer.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>United</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4608 Harlan Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. McKay</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Wixson</b>			16. ADDRESS <b>4608 Harlan St. Rockville, Md.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 579-12-9814</b>		17. INFORMANT <b>Dorothy E. McKay</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiogenic shock</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from <b>7/26/80</b> , 19, to <b>7/28/80</b> , 19, that (II) (we) lost saw the deceased alive on <b>7/28/80</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) had (did not) view the body after death.										
22b. SIGNATURE <b>Pasqual Perrino</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/28/80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Pasqual Perrino</b>				22e. ADDRESS <b>15 E. Deerpark Dr., Gaithersburg, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery Rockville, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		24b. ADDRESS <b>8434 Ga. Ave. Sil. Spr., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Pastor McBratney</b>				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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*[Handwritten text]*

1900-00-00  
1900-00-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

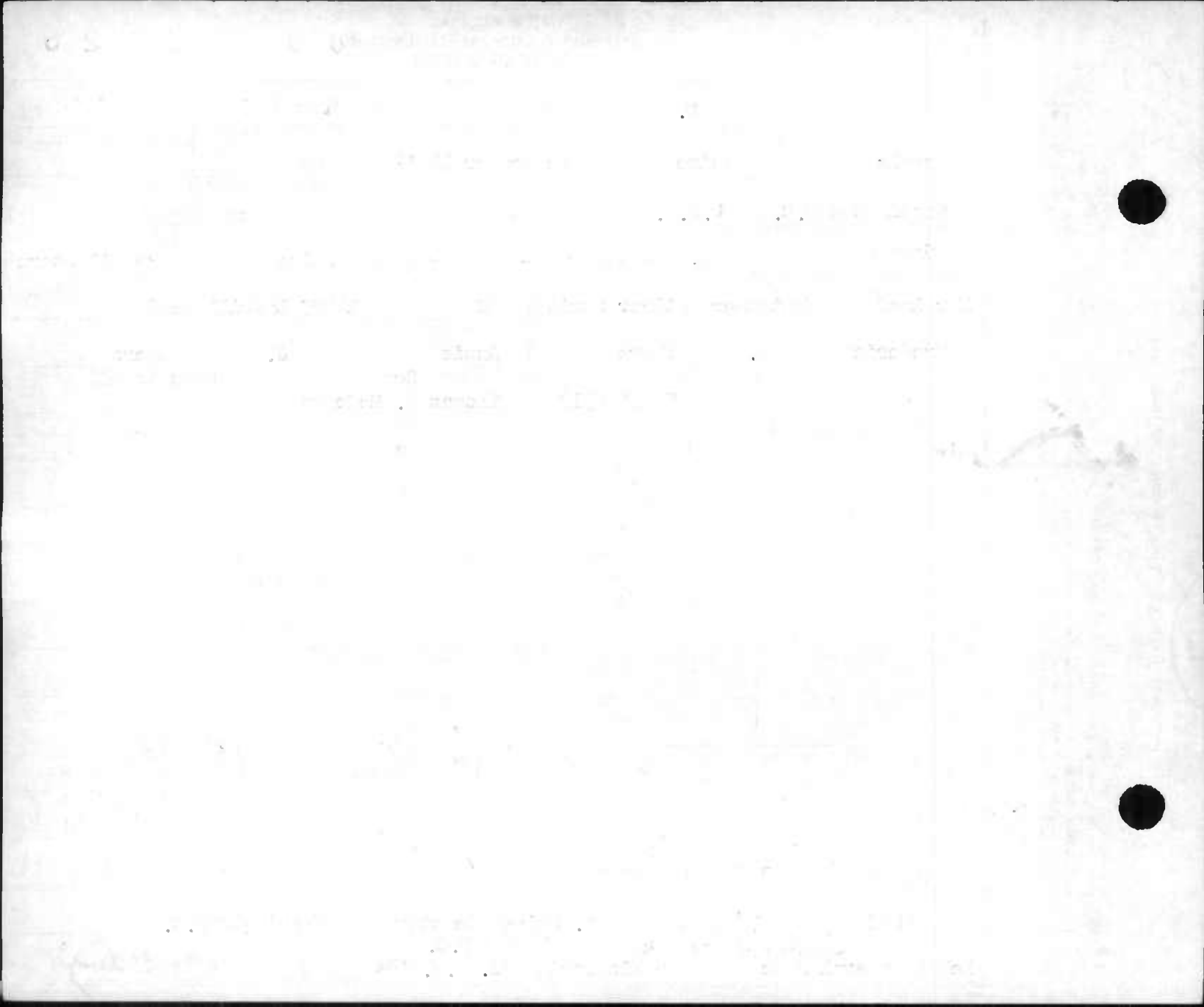
IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary D. McKenna			2a. DATE OF DEATH MONTH DAY YEAR July 8. 1980		2b. HOUR # 3:20 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 14 '16		
6. AGE (IN YEARS LAST BIRTHDAY) 63		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Retail Store		13. STREET ADDRESS 14423 Layhill Road		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick A. Poore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie J. Myers		16. SOCIAL SECURITY NO. 579 20 5514		
17. INFORMANT Son Thomas F. McKenna		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19. ADDRESS Same as #13		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intoxicated impaired reflexes</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ABR</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Statin not at premeditation 1/2 hr</u>						
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		
21j. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21k. DATE OF OPERATION		21l. DATE OF INJURY		
22. I certify that (I) (this hospital) attended the deceased from <u>7/6/80</u> to <u>7/8/80</u> , that (I) (we) last saw the deceased alive on <u>7/6/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)						
22a. SIGNATURE <u>Robert A. DeVol</u>		22b. DEGREE DEGREE		22c. DATE SIGNED 7/8/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert A. DeVol</u>		22e. ADDRESS <u>1811 P. Philip Dr. Chevy Chase</u>		22f. DATE SIGNED 7/8/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/11/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		23e. DATE REC'D. BY REGISTRAR JUL 17 1980		23f. REGISTRAR'S SIGNATURE <u>Robert A. DeVol</u>		
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		24b. ADDRESS 2222 Wisconsin Ave. N.W.		24c. DATE REC'D. BY REGISTRAR JUL 17 1980		





FOR  
1 - STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 6 2 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eugene Francis McNabb Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-30-80</i>		2b. HOUR <i>12:35AM</i>
3. SEX <i>Male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 29, 1980</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>2 hours</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD		
10. CITY OR TOWN OF DEATH <i>Olney</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>1500 Colesberg Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Eugene Francis McNabb</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Beverly Jean Robert</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Father Eugene F. McNabb</i> ADDRESS <i>same as 13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Immaturity - Transverse Birth</i> <i>7651</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Incompatible With Life</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Outside uterus</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert Shearin</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Shearin</i>		22e. ADDRESS <i>18111 Prince Phillip Dr. Olney, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Aug. 1, 1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>	23e. DATE REC'D. BY REGISTRAR <i>AUG 8 1980</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		25. REGISTER'S SIGNATURE <i>Robert Shearin</i>			
500 University Blvd., W. Silver Spring, Md.					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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July 29, 1950

Office

USA

Department of State

Washington, D.C.

Foreign Affairs

Room

Director

Mr. F. B. Hall

July 29, 1950

UNITED STATES DEPARTMENT OF STATE

Washington, D.C.

July 29, 1950

Mr. F. B. Hall

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 6 2 8  
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) <b>DANIEL William Mikaitis</b>		7 4 80		3 22 AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	8 IF UNDER 1 YEAR	
Male	Caucasian	Oct 5, 1911	68 YRS	MONTHS DAYS HOURS MIN.	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Connecticut	U.S.A.		Montgomery MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Adventist Hospital	Administrative	Gov't		
13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS					
Maryland		Pr. Geo. Lanham		12323 Lanham Severn Road	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME		
Peter Mikaitis			Josephine Ostrosky		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
yes		044 01 1120		Mary Mikaitis Same as # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Electromechanical Dissociation</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410 - DUE TO, OR AS A CONSEQUENCE OF <u>Acute Myocardial Infarction</u>					20 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Disease</u>					3 days
					Unk
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic Cardiovascular Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>July 2</u> 19 <u>80</u> to <u>July 4</u> 19 <u>80</u> , that (1) <u>was</u> lost saw the deceased alive on <u>July 3</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (2) <u>was</u> (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Robert Di Biano		MD		7/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DIBIANCO, ROBERT		CARDIO. DIV / WASH. ADVENTIST HOSP TAKOMA PARK, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7 July 80		St. James Cemetery	
23d. LOCATION CITY OR TOWN		23e. STATE			
Naugatuck, Connecticut					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert G. Beall Funeral Home		JUL 9 1980		P. J. Kelly	
9013 Annapolis Rd. Lanham, Md. 20801					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HEDWIG ELSIE MILLER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7 15 80</b>			2b HOUR <b>8<sup>30</sup> P.M.</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>2 13 00</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS <b>80</b>		8 IF UNDER 24 HRS HOURS MIN <b>80</b>	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Switzerland</b>		9b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
12 CITY OR TOWN OF DEATH <b>Chevy Chase</b>		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Nursing Center</b>				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			15 KIND OF BUSINESS OR INDUSTRY <b>--</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
16a STATE <b>Maryland</b>		16b COUNTY <b>Pr Geo</b>		16c CITY OR TOWN <b>Hillcrest H</b>		16d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16e STREET ADDRESS <b>2712 Fairlawn Street</b>			
17 FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Birkle</b>				18 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Gass</b>							
19a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				19b SOCIAL SECURITY NO. <b>578 62 0242</b>		19c INFORMANT <b>Elsie L. Messina</b>		19d ADDRESS <b>4605 Marie St. Beltsville, Md.</b>			
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance</b> 5939 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Comp. heart failure, atherosclerosis heart lesion</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
21a DATE OF OPERATION <b>7/15/80</b>				21b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4/21/80</b>				21c AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		22c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
23a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				23b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c LOCATION STREET CITY OR TOWN COUNTY STATE					
24 I certify that (I) (this hospital) attended the deceased from <b>7/15/80</b> 19 <b>7/15/80</b> 19, that (we) last saw the deceased alive on <b>7/15/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
25 SIGNATURE <b>Robert E. Wilhelm</b>				26 DEGREE <b>MD</b>				27 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		28 DATE SIGNED <b>7/15/80</b>	
29 PHYSICIAN'S NAME (TYPE OR PRINT) <b>BIRSCHBAH</b>				30 ADDRESS <b>10401 Adelger Road Bethesda Md</b>							
31 BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				32 DATE <b>18 July 1980</b>		33 NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		34 LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>			
35 FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b>				36 ADDRESS <b>Suitland, Md</b>				37 DATE REC'D. BY REGISTRAR <b>JUL 22 1980</b>		38 REGISTRAR'S SIGNATURE <b>[Signature]</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 3 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martin W. Miller, Jr			2a. DATE OF DEATH MONTH DAY YEAR 7-18-80		2b. HOUR 2:15 P.M.
3. SEX Male	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 6-4-25		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNT MGR.		12b. KIND OF BUSINESS OR INDUSTRY P.E.P. Co
13a. STATE MARYLAND		13b. COUNTY PR. GEO'S W. HYATSVILLE	13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 2425 HANNON STREET	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM M. MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA BRATNER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II	
16a. SOCIAL SECURITY NO. 236-28-5358		17. INFORMANT JANET S. MILLER		ADDRESS (SAME AS #13 ABOVE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Myocardial Infarction @ Artery 410- DUE TO, OR AS A CONSEQUENCE OF (b) - Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/1/79 to 7/18/80, that (I) (we) last saw the deceased alive on 7/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE (Signature)		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIVOK C VAID		22e. ADDRESS 7676 New Hampshire Ave #308 Langley Park			
23a. BURIAL SPECIAL REMOVAL	23b. DATE July 22-1980	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln		23d. LOCATION Baltimore Rd. P.O. Box 60. Md.	
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME		ADDRESS 7111 Wash, D.C.		DATE REC'D. BY REGISTRAR JUL 24 1980	
25. REGISTRAR'S SIGNATURE (Signature)					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

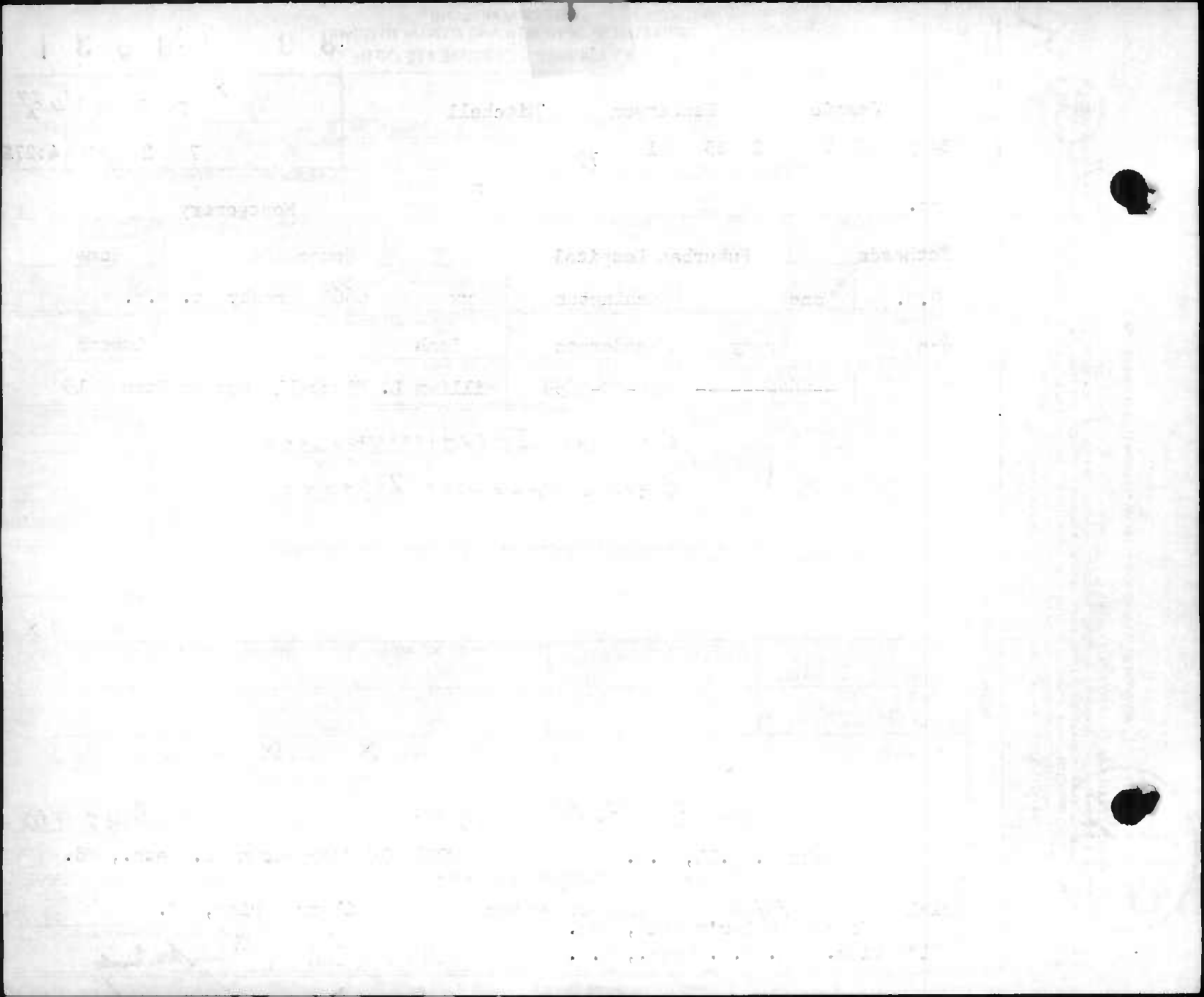
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DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80. 18631

1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jessie Henderson Mitchell</b>									
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 25 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 YRS.</b>		IF UNDER 1 YR. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		2b. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR <b>7- 2- 1980</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>None</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6669 Barnaby St. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Brady Henderson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Simpson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>229-70-9859</b>		17. INFORMANT ADDRESS <b>William L. Mitchell Same as Item # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>411- IMMEDIATE CAUSE (a) Coronary Insufficiency Acute</b> DUE TO, OR AS A CONSEQUENCE OF <b>(b) Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>July 2, 1980</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd. Beth., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/5/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John G. Brady</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 18632

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
John H. Mitchell		July 19 80		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
M	W	6-7-1900	79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Warren, Pa.		U. S. A.		Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Syl. Spg		3423 S. Leisure World Blvd. Apt 2F		Sales Rep. Retired	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Md		Syl. Spg		3423 S. Leisure World Blvd. Apt 2F	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Hugh Eugene Mitchell		Eona Campbell		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS	
318-10-7869		Ione M. Clarkson		3425 S. Leisure World Blvd. S.S. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Chronic Myocardial Dis.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers		M.D. 0-4		Jw 4/26/1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
John S. Rogers		Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		7/29/80		Metropolitan Crematory	
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		24b. LOCATION	
Ma Broshaw		8434 Ga. Ave.		Rockville, Md.	
Warner E. Pumphrey, Inc.		Silver Spring, Md.		AUG 04 1980	

*[Faint, illegible handwritten text covering the majority of the page]*

1000 4 1980  
B. B. B. B. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 1 8 6 3 3  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MALTA MOLDAUER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7 17 80</b>		2b HOUR <b>3:25 P.M.</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>CAUC.</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>12 25 94</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10 CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY -----
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>	13c CITY OR TOWN <b>Bethesda</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Morris Rothstein</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Marshie</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>070-28-2632D</b>		17 INFORMANT ADDRESS <b>Washington, D.C.</b> <b>Dr. Irving M. Rothstein; 4501 Conn. Ave. NW</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASCAD - HBP / CHF, hypothyroidism, psychosis / OBS</b>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (this hospital) attended the deceased from <b>12 12 19 72</b> to <b>7 - 17 19 80</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>7 17 19 80</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.						
22b SIGNATURE <b>Marsha Wallace</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>7/17/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARSHA T. WALLACE</b>		22e ADDRESS <b>MD</b>		22f ADDRESS <b>6121 Montrose Rd Rockville, Md.</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>July 20, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn, New York</b>
24 FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels;</b>		ADDRESS <b>1170 Rockville Pike</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 22 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 6 3 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SADIE A. MONTAGUE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-16-80</b>			2b. HOUR <b>8:45 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 13 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg</b>		13c. CITY OR TOWN <b>Brookville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Neugent</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Holland</b>		16. STREET ADDRESS <b>21021 New Hampshire Ave</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>198-26-5711</b>		17. INFORMANT ADDRESS <b>Maude Hill - 20001 New Hampshire Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5829 IMMEDIATE CAUSE (a) PNEUMONIA 24 HOURS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CRONIC RENAL Desease 5 years</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-12-1979</b> to <b>7-16-1980</b> , that (I) <del>last</del> saw the deceased alive on <b>7-14-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I <del>did not</del> view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-16-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON LENKIN, M.D.</b>		22e. ADDRESS <b>2309 Shorefield Rd, Wheaton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7.19-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Mem. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sandy Spring Montg Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		24b. ADDRESS <b>246 N. Wash St. Rockville, Md.</b>		25a. DATE REG'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as to the cause of death. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as to the cause of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 6 3 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLAUDE Edwin MORAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>7 9 80</b>			2b. HOUR <b>736P</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 6, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BRIGGS PLUMBING CO.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>PRI GEO</b>		13c. CITY OR TOWN <b>CAPITAL HEIGHTS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEWIS E. MORAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MODIE PENN</b>		13e. STREET ADDRESS <b>809 GLACIER AVENUE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-07-7589</b>		17. INFORMANT <b>HELEN POST MORAN</b>		ADDRESS <b>SAME AS 13</b>		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aspiration</b> <b>4273</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>atrial fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> 19 <b>80</b> to <b>7/9</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/9</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Brian H. Chin</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/10/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN AVIN</b>					22e. ADDRESS <b>8330 CAMERON ST., SILVER SPRING, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/14/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>				

1.2.9 3.9. VOTCHU2

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 3 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHLEEN (NMI) Moriarty			2a DATE OF DEATH MONTH DAY YEAR 7 21 80		2b HOUR 12:55 PM
3 SEX FEMALE	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR Aug. 25 1926		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland	7b CITIZEN OF WHAT COUNTRY? Ireland	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper	12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Montg.	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Eugene (NMI) Moriarty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anne Coronin			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Joseph J. Fisher (Same as 13e)	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) VARICEAL BLEEDING.

5724

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) HEPATO - RENAL SYNDROME

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

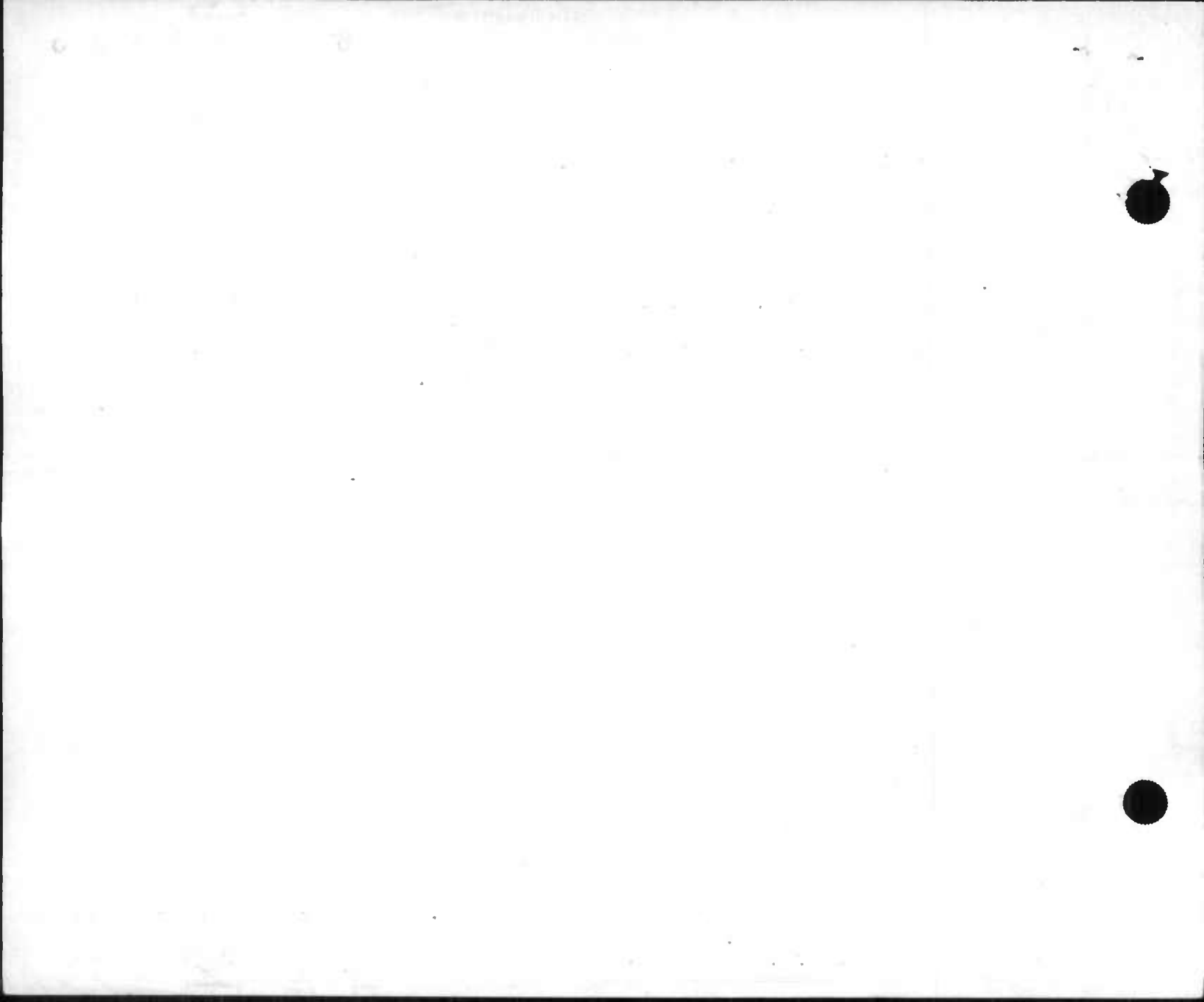
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/28/1980 to 7/21/1980, that (I) (we) lost saw the deceased alive on 7/30/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b SIGNATURE Tony P. Kannarkat MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 7/21/80
22d PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KANNARKAT		22e ADDRESS 8201 16th ST SILVER SPRING, MD 20910	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 7-30-80	23c NAME OF CEMETERY OR CREMATORY Killorglin Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Killorglin Kerry Ireland
24 FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland		25a DATE REC'D. BY REGISTRAR JUL 22 1980	25b REGISTRAR'S SIGNATURE Dorothy McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 6 3 7  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA MAUD MORLOCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 19 80</b>			2b. HOUR <b>11:00 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 4 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VERMILION HOUSE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SOCIAL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FED. GOVT.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>VIRGINIA</b>				13c. CITY OR TOWN <b>ARLINGTON ARLINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1530 So. EDGEWOOD ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>(UNKNOWN) - MORLOCK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(UNKNOWN) - OVERHOLT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. JACOB SEIDENBERG</b>		ADDRESS <b>6318 CAVALIER CDR FALLS CHURCH - VA.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis - massive</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Congestive Heart Failure</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1</b> , 19 <b>76</b> , to <b>July 19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (we) (did not) view the body after death.									
22b. SIGNATURE <b>H.A. Grennan</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H.A. GRENNAN</b>				22e. ADDRESS <b>1145-19th St. N.W. Washington, DC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>			23b. DATE <b>July 21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON MEDICAL SCHOOL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS CO.</b>				25a. ADDRESS <b>SILVER SPRING - MARYLAND</b>		25b. REG. NO. BY REGISTRAR <b>JUL 28 1980</b>		25c. REGISTRAR <b>J. J. J.</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Betty Ann Morris</i>			2a DATE OF DEATH MONTH DAY YEAR <i>July 17, 1980</i>			2b HOUR MIN. <i>9 26 AM</i>	
3 SEX <i>Female</i>	4 RACE <i>Black</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Feb. 13, 1932</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>48</i>	IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		IF UNDER 24 HRS HOURS MIN. <i>MD.</i>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i>			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Takoma Park</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>636 Houston Avenue</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hammie Jones</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Joe Ella Madden</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578 44 8678</i>		17. INFORMANT ADDRESS <i>Calvin Morris-Husband-636 Houston Avenue</i>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver failure - hepatic coma 2° to</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>alcoholic hepatitis - chronic</i>	<i>years.</i>
	(c) <i>alcoholism</i>	<i>years.</i>
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):	

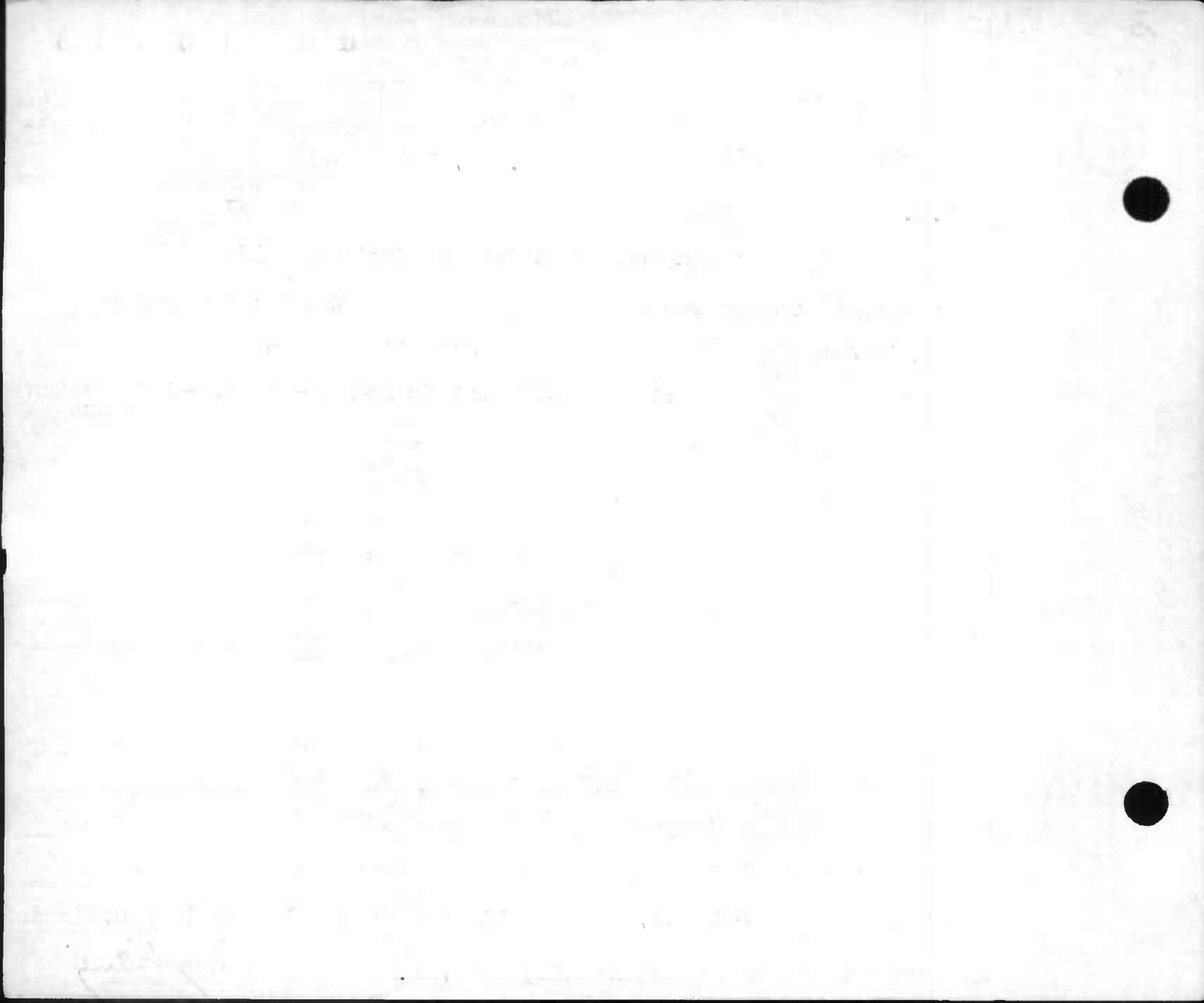
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>7/17</i> , 19 <i>80</i> , to <i>7/17</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/17</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Klaus W. Brennwald MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>7/17/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BRENNWALD</i>		22e. ADDRESS <i>831 University Blvd E Silver Spring MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>July 22, 1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arlington, Virginia</i>
24 FUNERAL DIRECTOR NAME <i>John T. Stewart Jr.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 29 1980</i>	25b. REGISTRAR'S SIGNATURE <i>Dorothy McCreedy</i>
Stewart Funeral Home-4001 Benning Road, NE.			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 8 6 3 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Dugan Morris				2a. DATE OF DEATH MONTH DAY YEAR July 25, 1980		2b. HOUR 11:00 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 16, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7616 Masena Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John F. Dugan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Twomey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-50-5124		17. INFORMANT Mrs. Mary M. Fortunato					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>atherosclerotic heart disease</i> 4440 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from saw the deceased alive <i>July 21, 1980</i> above, (b) we (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stanley M. Silverberg</i>				22c. DATE SIGNED July 28, 1980		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley M. Silverberg, M.D.			
22e. ADDRESS 5530 Wisconsin Ave. Chevy Chase, Md.				22f. DATE REC'D. BY REGISTRAR AUG 04 1980					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 29, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland				25. DATE REC'D. BY REGISTRAR AUG 04 1980					

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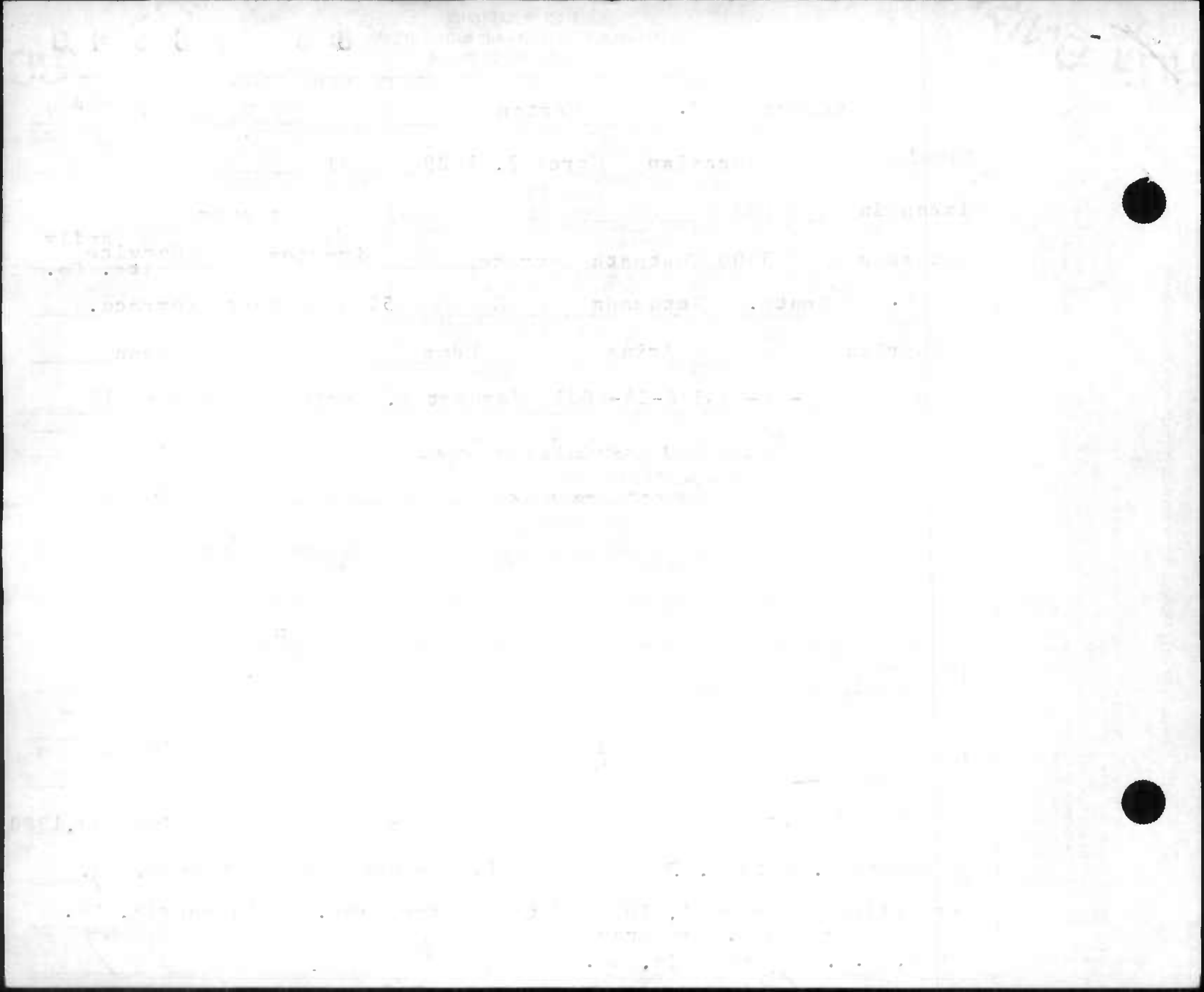
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 8 6 4 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathryn A. Morton				2a. DATE OF DEATH MONTH DAY YEAR 7 30 80		2b. HOUR 8:00 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1929		6. AGE (IN YEARS (LAST BIRTHDAY)) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5000 Westpath Terrace		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director		12b. KIND OF BUSINESS OR INDUSTRY Family Service Montg. Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Aring				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Homann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR CARD NO.) 396-24-8651		17. INFORMANT ADDRESS Herbert C. Morton Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cancer esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 nos</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>low</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 30</u> 19 <u>80</u> to <u>JULY 30</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>JULY 15</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Herbert L. Kotz MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 30, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. Kotz M.D.				22e. ADDRESS 10215 Fernwood Road Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 31, 1980		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR AUG 6 4 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



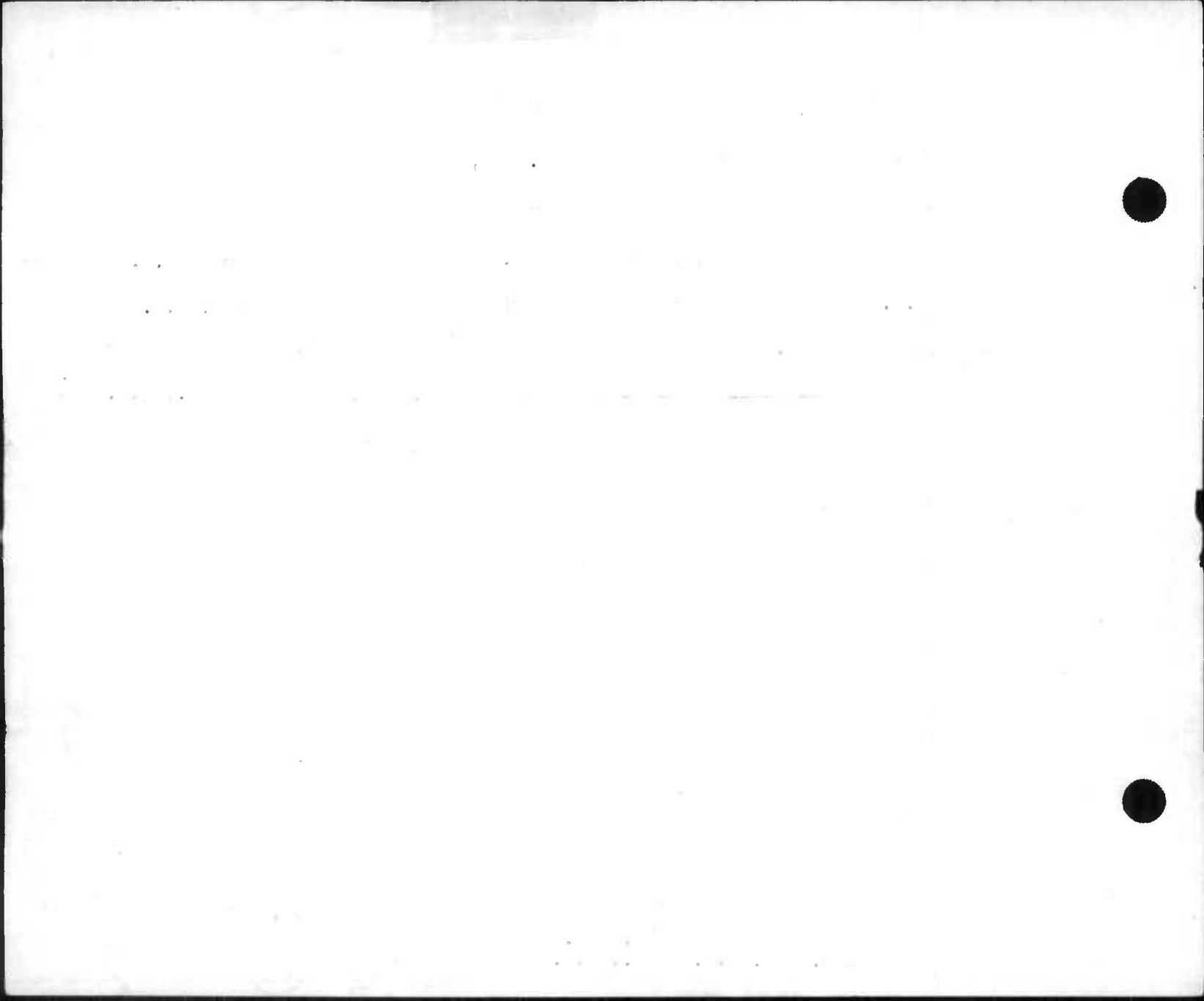
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 8 6 4 1 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Alta Turner Moyer				2a. DATE OF DEATH MONTH DAY YEAR 7 3 80		2b. HOUR 2:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Bethesda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptroller		12b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury	
13a. STATE D.C.		13b. COUNTY None		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2801 Quebec St. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry L. Turner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sena M. Faber							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-46-0196		17. INFORMANT ADDRESS 2801 Quebec St. NW Kathleen R. Southey-Friend Wash., D.C. 20008					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic obstructive Lung Disease</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes (PULMONARY FAILURE)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 yrs.</u> <u>5 yrs.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>7-3</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Herbert L. Tanenbaum MD</u> DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7-3-80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. TANENBAUM		22e. ADDRESS 5480 Wisconsin Ave Chevy Chase Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/80		23c. NAME OF CEMETERY OR CREMATORY Clay Cemetery		23d. LOCATION CITY OR TOWN COUNTY Genoa, Ohio		STATE <u>OHIO</u>	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016				25a. DATE REC'D. BY REGISTRAR JUL 8 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP







FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MERYL LOUISE MOYERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 7, 1980</b>		2b. HOUR <b>12:10AM</b>								
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. STATE <b>Maryland</b>						13b. COUNTY <b>n/a P.G.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13543 Youngwood Turn</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roger McDougald</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Castleberry</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>438-56-8771</b>			17. INFORMANT ADDRESS <b>Mr. James W. Moyers, Husband (same as above)</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Resp Arrest</b> 5070 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anoxic Brain Injury</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration Pneumonitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>8 day</b> <b>8 day</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CML in Blast Crisis S/P ChemRx</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>June 27, 1980</b> to <b>July 7, 1980</b> , that (X) (we) last saw the deceased alive on <b>July 7, 1980</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE <b>Robert E. Parker MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>7/7/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert E. Parker</b>					22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, MD 20205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1980 July 9</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Felder Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Port Vincent, La.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Capitol Funeral Service Fairfax, Va.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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U.S.A.

Page 1

Page 2

Page 3

Page 4

12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 4 3  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET J. MULVEHILL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 21 80</b>		2b. HOUR <b>4:00 P</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 13, 1892</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Bethesda</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5901 Cromwell Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Furr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Anderson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-10-4340</b>		17. INFORMANT ADDRESS <b>Charlotte M. Schmidt Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>5570 Peritonitis</b> IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF (b) <b>mesenteric occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>post operative adhesion</b>					APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION <b>7-7-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small bowel gangrene</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-7-80</b> to <b>7-21-80</b> , that (I) (we) last saw the deceased alive on <b>7-21-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James P. McParrick M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-22-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES P. MCPARRICK</b>		22e. ADDRESS <b>809 VIER'S MILL ROAD Rockville Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>Jul. 24, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Maus.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensb urg, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McHenry</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.</b>					

MEDICAL CERTIFICATION

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1987 JUL 28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 4 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Agnes C. Mulvihill			2a. DATE OF DEATH MONTH DAY YEAR 7/31/ 80		2b. HOUR 12:01 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Clerk	12b. KIND OF BUSINESS OR INDUSTRY County Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE New Jersey			13b. COUNTY Atlantic	13c. CITY OR TOWN Atlantic City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Peter -- Tyrrell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes -- Bowen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 154-22-2117	17. INFORMANT ADDRESS Marie M. Rooney, Bethesda, Md. 5202 Alta Vista Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u> 4410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Dissecting Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Atherosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Head &amp; Neck Cancer (Tongue primary)</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>1979</u> to <u>3/10</u> 19 <u>80</u> , that (1) <u>we</u> lost saw the deceased alive on <u>3/10</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) <u>not</u> view the body after death.					
22b. SIGNATURE <u>Stephen J. Newman</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/1/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman		22e. ADDRESS 5411 W. Cedar La., Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE 8/2/80		23c. NAME OF CEMETERY OR CREMATORY Laurel Memorial Pk.	
23d. LOCATION CITY OR TOWN Pomona, New Jersey		23e. COUNTY New Jersey		23f. STATE	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wis. Ave., NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR AUG 7 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18a is marked, or item 18b is marked, or item 18c is marked, the medical examiner must be notified at once.

80-100-44

Aug 11 1944

Individual

James

White, James H. 1913

Northampton

U.S. Army

Enlisted

Eastern Hospital

Benning

Atlantic City

Married

Major

194-22-111-111

*[Faint, mostly illegible text, possibly a letter or report, covering the middle section of the page.]*

AUG 11 1944

1944-22-111-111

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.15  
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Roderick Murray</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 30 1980</b>			2b. HOUR <b>1245P</b> M				
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 12 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Zealand</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Health</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION) 13a. STATE <b>D.C.</b>					13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5714 Springfield Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kenneth Murray</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary McLeod</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Mrs. Barbara Murray, See item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED - (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 25</b> , 19 <b>80</b> , to <b>July 30</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>July 30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.										
22b. SIGNATURE <b>M.D. Browning</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>July 31 1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. D. Browning, M.D.</b>						22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Aug. 1. 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>						300 4th St N.E. ADDRESS <b>Washington, D.C.</b>		25. FILE REC'D. BY REGISTRAR <b>AUG 5 1980</b>		

BP \_\_\_\_\_



Washington, D.C.

AUG 1970

Mr. J. B. Lee's Secretary

Room 300



BP  
 DHMH-17  
 (VR A15 ME (5))  
 15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

18646

 FOR  
 1- STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert John Napora			2a. DATE KNOWN OF DEATH ESTIMATED 7 12 1980			2b. HOUR M 7:40 A.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 16 56	6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 7 12 1980	2d. HOUR 7:40 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 907 Rosemere Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		
12b. KIND OF BUSINESS OR INDUSTRY Const.								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. CITY OR TOWN Anne Arundel Laurel		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3367 Wye Mills South		
14. FATHER'S NAME FIRST MIDDLE LAST John J Napora				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Wells				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-64-9393		17. INFORMANT 3367 Wye Mills So. John J. Napors Laurel, Md. 20810				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:30x 7 12 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 907 Rosemere St., Silver Spring, Montgomery Co Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Thomas D. Smith, M.D.		TITLE (SPECIFY) Deputy Chief				DATE SIGNED 7-13-80		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/15/80		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.		
24. FUNERAL DIRECTOR NAME Fleck		ADDRESS Laurel		25a. DATE REC'D. BY REGISTRAR JUL 14 1980		25b. REGISTRAR'S SIGNATURE P.G. McBrady		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

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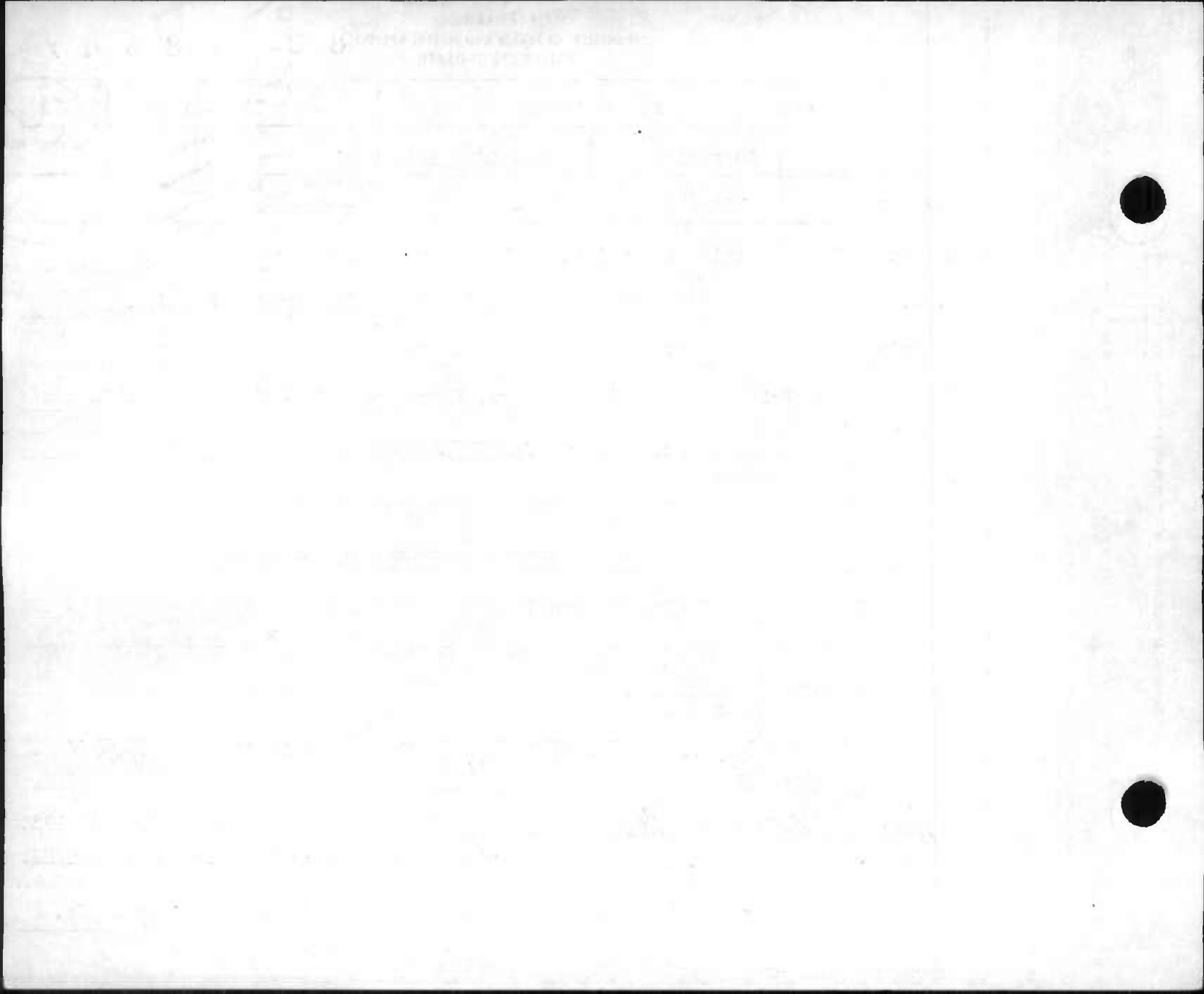
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7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert S. NATHAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 17 1980</b>		2b. HOUR <b>9:47P</b> M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 20 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. Army</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY <b>D. C.</b>		13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4529 Grant Road, N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Nathan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flora Rogers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1912-59 092 07 9090</b>	17. INFORMANT ADDRESS <b>Mrs. Flora Haas, 25 Marion Road, Arlington/Mass.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial INFARCTION</b> <b>410 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 16</b> , 19 <b>80</b> , to <b>July 17</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July 17</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. <b>80</b>					
22b. SIGNATURE <b>Mark O. Browning M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>July 18 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark O. Browning, M.D.</b>		22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-22-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky Goldberg Memorial Chapel Rockville</b>		ADDRESS <b>Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 22 1980</b>	



Item 16 B G 546 8/5/80 GB

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 4 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>George R. Nelligan</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7-18-80</b>			2b HOUR <b>9 30 AM</b>			
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4904 Arbutus Avenue</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager Shoestore</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Rockville</b>		13d STREET ADDRESS <b>4904 Arbutus Avenue</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>James A. Nelligan</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Maloney</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WWII 540-22-7148</b>		17 INFORMANT <b>wife</b>		ADDRESS <b>Helen A. Nelligan same as 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1509</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>11/79</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>7/1/80</b> 19____, to <b>7/18/80</b> 19____, that (I) (we) last saw the deceased alive on <b>7/1/80</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Jeremy V. Cooke</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>7/18/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cooke Jeremy V. Cooke</b>				22e ADDRESS <b>10400 Penn Ave Kensington</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Jul. 22, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>			
500 University Blvd. W. Silver Spring, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, no further action is required.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

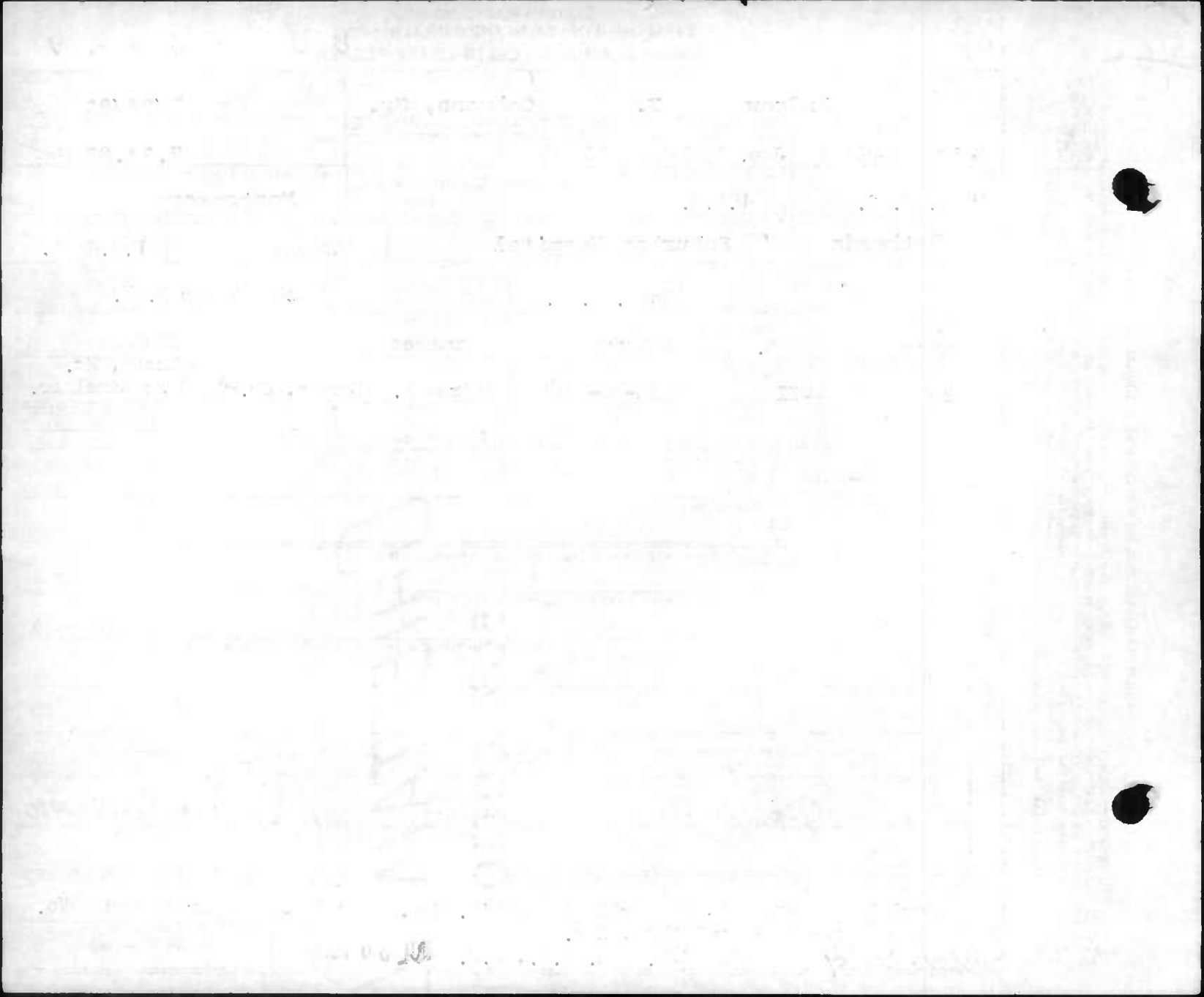
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 8 6 4 9

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Andrew F. Oehmann, Sr.		7/24/80		5:40 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	Jan. 29 1910	70 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Wash. D. C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)	
Bethesda		Suburban Hospital		Attorney	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
47		Wash. D. C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Andrew L. Oehmann		Frances Kiely		213-40-9714	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		ADDRESS Bethesda, Md.	
Yes		WWII		Andrew F. Oehmann, Jr. 4956 Sentinel Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Ball		M.D. Deputy		July 24, 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		July 28, 80		Arlington Nat'l. Cem.	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Arlington		Arlington Va.		JUL 30 1980	
24. FUNERAL DIRECTOR					
DeVol Funeral Home, Inc.					
2222 Wisc. Ave. N.W., D.C.					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Francis M Onley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07 24 80</b>			2b. HOUR MIN <b>4:30AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 13, 1916</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>64</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hosp. Olney</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Rd. Comp</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Germantown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19313 St. Johnbury Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry T. Onley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Fisher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>723-14-8291</b>		17. INFORMANT ADDRESS <b>Larry Onley (son) same as #13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the</b> <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>166 3 months</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>166 3 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>7-22-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>18111 Prince Phillip Dr., Olney, Md. 20832</b>					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.									
22b. SIGNATURE <b>Mario H. Diaz</b>				DEGREE <b>Attending Physician</b>				22c. DATE SIGNED <b>7-26-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mario H. Diaz, M.D.</b>				22e. ADDRESS <b>18111 Prince Phillip Dr., Olney, Md. 20832</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sellman, Montg. Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>George R. Snowden 246 N. Washington Street Rockville, Md. 20850</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>					

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TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

18651

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NELLIE O. OURS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 27 80</b>			2b. HOUR <b>8<sup>00</sup> A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 13 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. STREET ADDRESS <b>4201 Federal Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cecil Upton Schriver</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Russella Hill</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>217 18 4638</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Page same as 13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>3599</b> IMMEDIATE CAUSE (a) <b>Some Cardio-vascular event</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Some Hypertension, with Cerebral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Progressive Muscular atrophy</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>July 14 1980</b> to <b>July 27 1980</b> , that (I) (we) last saw the deceased alive on <b>July 14 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or we) did (did not) view the body after death.							
22b. SIGNATURE <b>Benjamin Aronson, MD.</b>				22c. DATE SIGNED <b>7-27-80</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin Aronson, MD.</b>				22f. ADDRESS <b>3720 Forest Ave. Hunt Valley, Md 20815</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-30-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Buck Valley Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warfordsburg Fulton Pa.</b>	
24. FUNERAL DIRECTOR NAME <b>Richard J. Shaw</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

12081808

2008

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES SHERMAN OWENS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 7, 1980</b>		7b. HOUR <b>6:35 AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 21, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14707 LINDSEY LANE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PENOLOGIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14707 LINDSEY LANE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE WESLEY OWENS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANE MORRISON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO <b>578-40-5407</b>		17. INFORMANT ADDRESS <b>GERALDINE S. OWENS SAME AS 13 WIFE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cranium of Stomachic bacteria</u> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Diabetes Mellitus, Alcoholism</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>80 7/5 80</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE			22c. DATES SIGNED <b>7/8/80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wilson MD</b>			22e. ADDRESS <b>1811 P. Phillips Ave MD 20901</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JULY 9, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
<b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>										

6:25 A	JULY 7, 1960	OLIVE	SHERMAN	WHITE	WHITE
	75	JULY 21, 1962	XX		
	MONTGOMERY			"S.A."	NEW YORK
GOVERNMENT	TELEPHONE	14707 LINDEN LANE	SILVER SPRING	SILVER SPRING	
	14707 LINDEN LANE	X	MONTGOMERY SILVER SPRING	MONTGOMERY SILVER SPRING	
	WESTERN	JANE	WESTERN	WESTERN	GEORGE
WIFE	WIFE NO 12	DEBORAH C. OWENS	515-14-1407		

*Handwritten signature or scribble*

2500 W. 14TH ST., SILVER SPRING, MD. 20901  
 FRANCIS J. BRYAN  
 JULY 11, 1960  
 180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 1 8 6 5 3								
1 - STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louis Charles Paladini</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>July 22 80</i>					2b. HOUR <i>9:15 A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 21 1912</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS <i>67</i>		8. UNDER 24 HRS HOURS MIN. <i>9:15</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i> MD.						
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Banker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>National Madison</i>			
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3212 Wake Drive</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Louis C. Paladini</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nan Travis</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>577-07-5260</i>		17. INFORMANT <i>wife</i>			ADDRESS <i>same as 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Sepsis</i> <i>2500</i> DUE TO, OR AS A CONSEQUENCE OF (b): <i>Diabetes mellitus Cerebrovascular</i> DUE TO, OR AS A CONSEQUENCE OF (c): <i>Diabetes mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i> <i>8 years</i> <i>15 years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/22 80</i> to <i>22 July 80</i> , that (I) (we) lost saw the deceased alive on <i>7/22 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.													
22b. SIGNATURE <i>Ira N. Tublin</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>7/22/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ira N. Tublin, M.D.</i>					22e. ADDRESS <i>8830 Cameron Street Silver Spring, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Jul. 25, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 25 1980</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>					25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>								
500 University Blvd., W. Silver Spring, Md.													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 8 6 5 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MONROE C. Peeden		7 8 80		11:15A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
M	Caucasian	8 16 00	79 YRS	IF UNDER 24 HRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
N. Carolina	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	custodian	Board of Education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		13d. CITY OR TOWN	
Md. P.G.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	514 Compton St		LAUREL	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT ADDRESS			
Charles Peeden	Ardella Jerden	Lottie M. Peeden same as above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
no	214038831	Lottie M. Peeden same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest and</u> <u>1579</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute renal failure</u> <u>Carcinoma of Pancreas &amp; Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-4</u> 19 <u>80</u> to <u>7-8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-8</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>A. Shamim</u> MD		22c. DATE SIGNED <u>7-8-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANMAD SHAMIM, MD</u>		22e. ADDRESS <u>200 Ft. Meade Rd. Laurel Md.</u> <u>20816</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>July 10, 1980</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Donald H. H.</u>	25a. DATE REC'D. BY REGISTRAR <u>JUL 16 1980</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP \_\_\_\_\_

DHMH 16 25M  
(VRA 15, 4) 1/79



Silver Spring

Charles Feiden

no

Lottie M. Feiden same as above

Archie Jordan

custodian

Board of Educat  
ion

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2800 BP

DHMH-16 25M  
(VRA 15, 4) 1/791 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18655

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID PERLMUTTER</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>80</b>		7b. HOUR <b>9 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>23</b> YEAR <b>09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE MEAT</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8715 FIRST AVENUE</b>	
14. FATHER'S NAME FIRST <b>BENJAMIN</b> MIDDLE <b>PERLMUTTER</b> LAST <b>PERLMUTTER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>FREIDA</b> MIDDLE <b>BROWNSTEIN</b> LAST <b>BROWNSTEIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-01-3568</b>		17. INFORMANT ADDRESS <b>CLARA B. PERLMUTTER, same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2+ YRS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>AUG 19 78</b> to <b>JULY 22 19 80</b> , that (I) <del>last</del> saw the deceased alive on <b>JULY 22 19 80</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <b>Edward G. Beeman MD</b>				22c. DATE SIGNED <b>7-22-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD A. BEEMAN MD</b>				22e. ADDRESS <b>8830 CAMERON ST. SILVER SPRING MD 20910</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>7/23/1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ADELPHI, PR. GEORGES, MD.</b>	
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>P. Kelly</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward nmn Pernell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-31-80</b>			2b. HOUR <b>2:40p M</b>			
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 5 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vicksburg Miss</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>TA KOMA Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>7950-18 Ave Adel Phi-Md</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELIJAH PerneLL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lda Ford</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
17a. SOCIAL SECURITY NO. <b>484-01989</b>			17. INFORMANT ADDRESS <b>Luverna PerneLL 7950-18 Ave</b>						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>7 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Large Cell Carcinoma of Lung</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>27 mar</b> 19 <b>80</b> to <b>31 July</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11 July</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas A. Bensinger MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>31 July 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas A. Bensinger, MD</b>						22e. ADDRESS <b>8676 New Hampshire Ave, Langley Park, MD 20823</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>AUG 5-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland National</b>		23d. LOCATION CITY OR TOWN COUNTY <b>13300-WASH BLVD-LAUREL</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>S.B. Fisher 2116-18th St N.W.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 8 6 5 7

1. DECEASED NAME (TYPE OR PRINT) <b>Audrey M Peterson</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7/26/80</b>		2b. HOUR <b>9<sup>30</sup> P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood House</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Officer FAA</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7814 Moorland Lane</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Leroy Peterson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth W. Larson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 476-05-0016</b>		17. INFORMANT ADDRESS <b>Eau Claire, Wisc.</b> <b>Wesley Erickson, 3126 Mitchell Ave. N.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>3310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ALZHEIMER'S DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 9, 1980</b> 19 <b>80</b> to <b>July 26</b> 19 <b>80</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>July 9</b> 19 <b>80</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
22b. SIGNATURE <b>James A. Rossi MD</b>				22c. DATE SIGNED <b>7/27/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. ROSSI, MD</b>				22e. ADDRESS <b>6111 EXECUTIVE BLVD, ROCKVILLE, MD 20852</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ronald Lee PHILLIPS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 23 1980</b>		2b. HOUR <b>1210A M</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 16 1956</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>24</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Marine Corps</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>North Carolina Onslow Hubert</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Earl Phillips, Jr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margery Gail Ritzenthaler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1974-80 321 52 2451</b>		17. INFORMANT ADDRESS <b>Jeanette P. Phillips See item 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>Burkitt's Lymphoma</b> IMMEDIATE CAUSE (a) <b>2002</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from <b>March 12 1980</b> , to <b>July 23 1980</b> , that I (we) last saw the deceased alive on <b>July 23 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.					
22b. SIGNATURE <b>Dale W. Pcsolyar</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>July 23 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dale W. Pcsolyar, M.D.</b>		22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Naperville Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Naperville DuPage Illinois</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>W. W. Chambers Co. Silver Spring, Md.</b>			

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JUL 26 1980

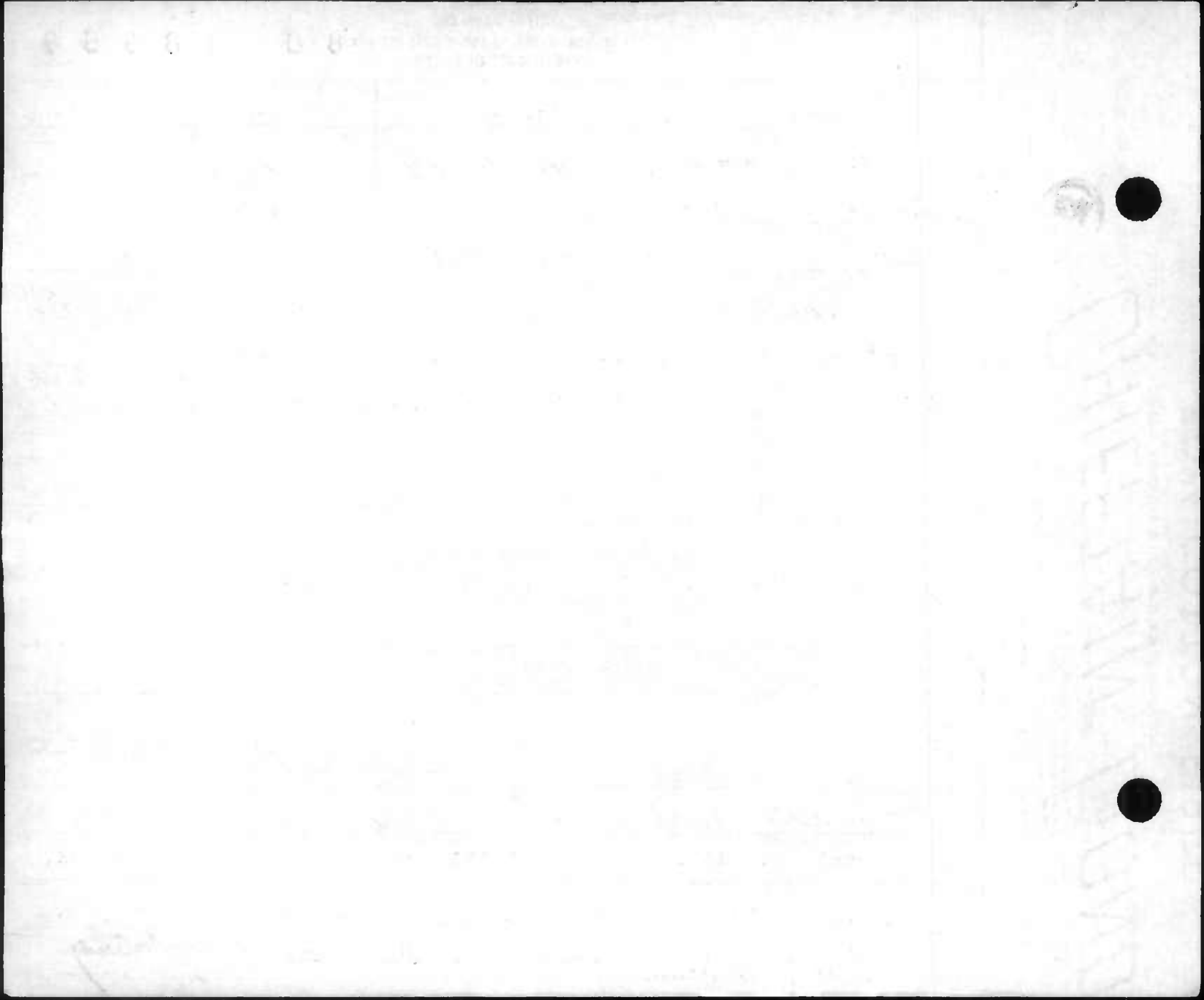
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 8 6 5 9	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy B. Plager						2a. DATE OF DEATH MONTH DAY YEAR July 4, 1980		2b. HOUR 8:45AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 16, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20 BRYANTS NURSERY RD.		
14. FATHER'S NAME FIRST MIDDLE LAST ORDWAY GENTRY BALLINGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR HARKLESS				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 26 6616	
17. INFORMANT ADDRESS ELEANOR BALLINGER 20 BRYANTS NURSERY SILVER SPRING, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinoma 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Adenocarcinoma of ovaries DUE TO, OR AS A CONSEQUENCE OF 18 mo 18 mo										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Partial bowel obstruction, ascites, electrolyte imbalance.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 78 to 4 July 19 80, that (I) (we) last saw the deceased alive on 3 July 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald E. Dillon M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4 July 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon						22e. ADDRESS 18111 Prince Philip Dr. Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7/5/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Brentwood PG Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md						25a. DATE REC'D. BY REGISTRAR JUL 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]			







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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018661	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Kent Worth PORTER					2a. DATE OF DEATH MONTH DAY YEAR July 21 1980			2b. HOUR 1015P M			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 3 1940		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst		12b. KIND OF BUSINESS OR INDUSTRY National Security			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. George 13c. CITY OR TOWN Laurel					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7616 Carissa Lane ty Agent				
14. FATHER'S NAME FIRST MIDDLE LAST George Worth Porter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Laurie Sines							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1959-65		17. INFORMANT ADDRESS Mrs. Carol E. Porter See item 13							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1590 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Adenocarcinoma of the bowel</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>May 21</u> , 19 <u>80</u> , to <u>July 21</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>July 21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George I. Gambler MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED July 22 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George I. Gambler</u> LTMC USMC					22e. ADDRESS National Naval Medical Center, Bethesda, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/25/80		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.					
24. FUNERAL DIRECTOR NAME Flick Funeral Home					ADDRESS Laurel, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 23 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia K. Hardy</u>		

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*Handwritten signature or initials.*

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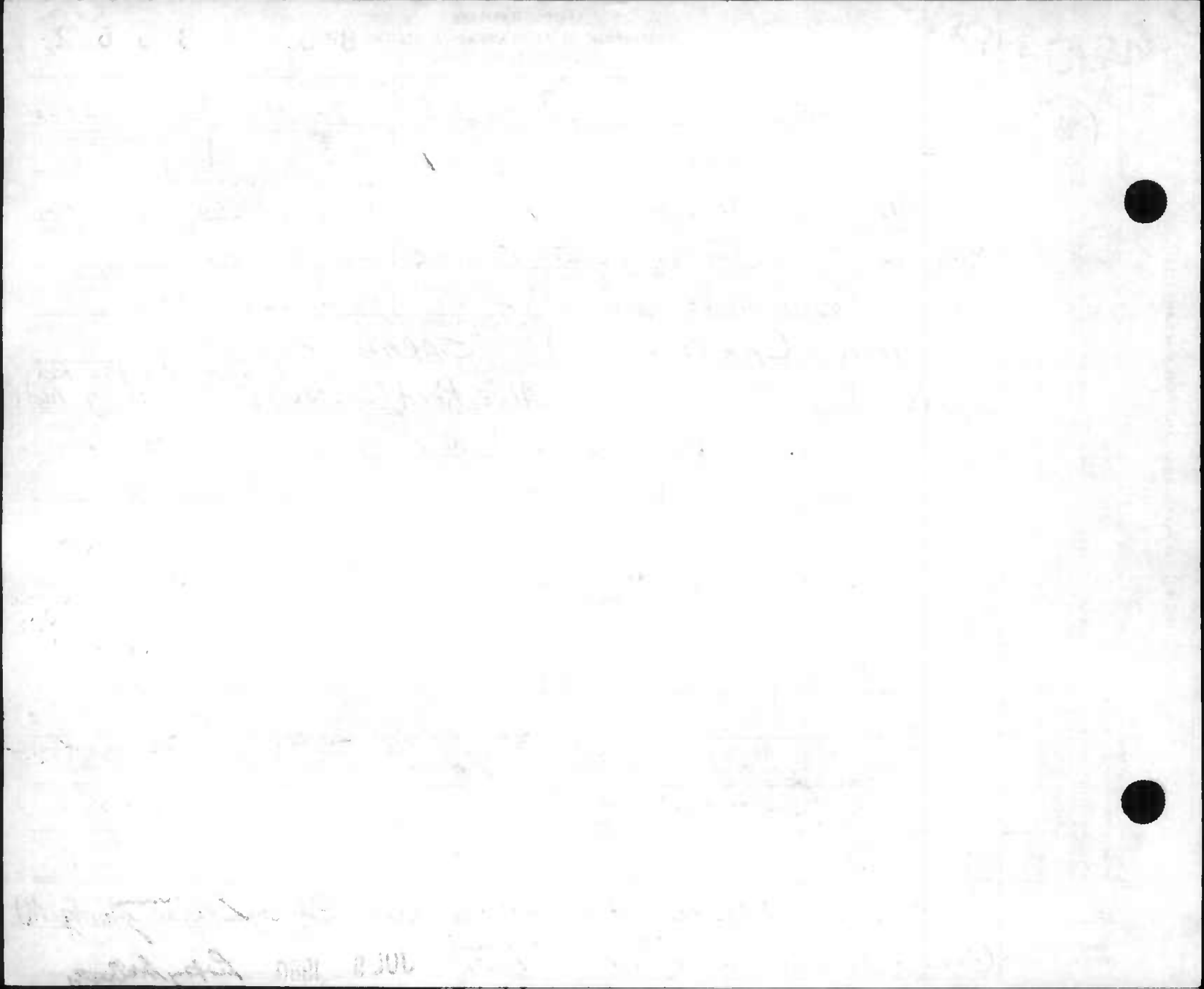


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												
CERTIFICATE OF DEATH												
REG. NO. 8 0 1 8 6 6 2												
1- FOR STATE REGISTRAR												
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL S QUARLES						2a DATE OF DEATH MONTH DAY YEAR 7-4-1980			2b HOUR 1:27 AM			
3 SEX F		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 11 5 04		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.						
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA HEALTH CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE Maryland		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3654 BEL PRE ROAD.				
14 FATHER'S NAME FIRST MIDDLE LAST Tom CARTER						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH BURGESS						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Alice Reed (sister) 3630 Bel Pre Rd. Silver Spring, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD &amp; Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Diabetes. Hypertension.</u>												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>11/5/78</u> 19 <u>78</u> , to <u>7/4/80</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>6/23/80</u> 19 <u>80</u> , and that in <u>my</u> <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.												
22b SIGNATURE <u>S.B. Goswami MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>7/4/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>S.B. GOSWAMI</u>						22e ADDRESS <u>5401 Gaysstone St. Ch. Ch. Md 20015</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b DATE <u>7-9-80</u>		23c NAME OF CEMETERY OR CREMATORY <u>ASH MEMORIAL Cem.</u>			23d LOCATION CITY OR TOWN COUNTY STATE <u>Shady Springs Montg Md.</u>			
24 FUNERAL DIRECTOR NAME <u>George R. Snowden</u>						24b ADDRESS <u>246 N. Wash. St. Rockville, Md.</u>		25a DATE REC'D. BY REGISTRAR <u>JUL 9 1980</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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DHMH-16 25M  
(VRA 15, 4) 1/79STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 6 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM HENRY RADCLIFFE</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>6</b> YEAR <b>80</b>		2b. HOUR <b>1027 AM</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH <b>March</b> DAY <b>24</b> YEAR <b>1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>	
10 CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrical Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Radcliffe</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Nellie</b> MIDDLE <b>Henry</b> LAST <b>Henry</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-03-8457</b>		17 INFORMANT <b>Nettie K. Radcliffe, Item 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Calculation of the tonsil</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Arrhythmias</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Cardiac Arrhythmias</b>					
19a. DATE OF OPERATION <b>7/6/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cardiac Arrhythmias</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/6 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/6/80</b> to <b>7/6/80</b> , that (I) (we) last saw the deceased alive on <b>7/6/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Martin W. Graf M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7/6/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN GRAF M.D.</b>		22e. ADDRESS <b>13-15 E. DEER PARK DRIVE MD. 20860</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 8, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montgomery, Md.</b>		24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, Damascus, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

U.S. Department of Justice

July 6, 1960

Arkham

Rockville, Montgomery, Md.

20

214-03-8157

Nettie K. Radcliffe, Item 13

William

H.

Radcliffe

Nettie

Henry

Arkham

Montgomery

Geithersburg

x

19520 Brassie Place

Rockville

Shady Grove Adventist

Electrical Engineer

Arkham

U.S.A.

x

March 24, 1967

73

Montgomery Co.,

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 6 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alton H. Radford</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07 24 80</b>		2b. HOUR MIN. <b>4:40AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 12, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>75</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montg. General Hosp. Olney</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>G.O.A.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Govt.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Damascus</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>26007 Woodfield Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Radford</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della (unknown)</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578 40 9114</b>	
17. INFORMANT <b>Norman Campbell</b>				ADDRESS <b>Item 13</b>					
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>486-</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Aortic Aneurysm Transitional cell carcinoma - bladder</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>6/9/80</b> , 19____, to <b>7/24/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/23/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert Millman</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/24/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Millman, MD</b>	
22e. ADDRESS <b>15 E Drer Park Dr Gaithersburg Md 20760</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 25, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Olin I. Molesworth, P.A. Damascus, Md.</b>				ADDRESS <b>JUL 28 1980</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Olin I. Johnson, P.A. Manager, 45.  
 Baltimore, Md. 1930  
 Baltimore, Md.

No 378 40 914 Norman Campbell Team 12  
 Radford Della  
 Maryland Maryland 20007 Woodfield Road  
 (unknown)  
 Fed. Govt. G.O.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY W.S. RAGAN</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>7.31-80</b>		2b. HOUR <b>3:15 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 14 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 74 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont.</b>			MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Claims Division</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>					
13a. STATE <b>MD</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Wash. D. C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2712 Wisconsin Ave. N. W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William B. Shute</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Whitney</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-54-4651</b>		17. INFORMANT ADDRESS <b>James F. Channing 3118 Rodman St. N. W.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410 - acute cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic mitral insufficiency</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 min</b> <b>3-5 min</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Hypertension; past stroke</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1980</b> to <b>July 31, 1980</b> , that (I) <del>was</del> last saw the deceased alive on <b>July 26, 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>R. Stephen Hulburt</b> DEGREE <b>MD</b>										22c. DATE SIGNED <b>July 31/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Stephen Hulburt, M.D.</b>										22e. ADDRESS <b>3000 Dent Pl. N. W., Washington, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 6, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wisconsin Dells Wisc.</b>					
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home, Inc.</b> ADDRESS <b>2222 Wisconsin Ave. N.</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DORSEY</b>		FIRST <b>DORSEY</b> MIDDLE <b>ENOCH</b> LAST <b>RAY</b>		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 29, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Ray</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Carter</b>		13e. STREET ADDRESS <b>2404 Weisman Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>579-05-7029</b>		17. INFORMANT ADDRESS <b>Hilda S. Ray Same as # 13</b>			

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410 - DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b>		35 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOGENIC SHOCK</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**Lung Cancer (Right upper lobectomy S/P) 6 weeks ago**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **7-21**, 19 **80**, to **7-23**, 19 **80**, that (I) (we) lost saw the deceased alive on **7-22**, 19 **80**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Alberto Rotsztain</b>	DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>7/23/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERTO ROTSZTAIN</b>		22e. ADDRESS <b>10401 Old Beaufort Rd. Bethesda Md. 20014</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>July 25, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Mont. Md.</b>
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24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>	<b>LAYTONSVILLE, MD. 20760</b>	25a. DATE RECEIVED BY REGISTRAR <b>JUL 26 1980</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES WALTER REED				2a. DATE OF DEATH MONTH DAY YEAR JULY 15 1980				2b. HOUR 0145 M	
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR DEC 8 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA				13b. CITY OR TOWN ARLINGTON		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4766 FIRST ST NORTH	
14. FATHER'S NAME FIRST MIDDLE LAST DONALD NELSON REED				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MELLA FULTON MCELROY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) DEC 40-JULY 61		17. INFORMANT ADDRESS BETTY JANE REED 4766 FIRST ST NORTH ARLINGTON VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC PANCREATIC CARCINOMA 1579 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 25 19 80 to JULY 15 19 80, that (I) (we) last saw the deceased alive on JULY 15 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. J. FAGAN DEGREE LT. MC. USNR ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED JULY 15-1 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. FAGAN, M.D.				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 18 July 80		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA.			
24. FUNERAL DIRECTOR NAME ARLINGTON FUNERAL HOME				ADDRESS ARLINGTON, VA.		25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE	

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U.S. Navy

Naval Reserve

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mardelle Lilly</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <b>July 21 1980</b>			2b. HOUR <b>6:20</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 5 1905 79 YRS.</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>79 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MINS	8. IF UNDER 24 HRS. HOURS MINS	2c. DATE PRONOUNCED DEAD <b>July 21 1980</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GEORGIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>St. Louis</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Randolph Hills Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STATISTICIAN</b>		
13a. STATE <b>Mo</b>			13b. COUNTY <b>Mont.</b>			13c. CITY OR TOWN <b>Cherry Chase</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>OSCAR JAMES LILLY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JAMIE JULIAN</b>			16. SOCIAL SECURITY NO. <b>521-16 9014A</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			17. INFORMANT <b>EVERT B. CLARK JR.</b>			ADDRESS <b>Potomac, Md. 9605 Pinkney Ct.,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Terminal Bronchial Pneumonia 2 days</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Fracture rt hip</b>								
19a. DATE OF OPERATION <b>June 6 80</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture rt hip</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>(P.M.) 6:45 1980</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in room</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Nursing Home Randolph Rd St. Louis</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Mont. Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John S. Rogers</b>			TITLE (SPECIFY) <b>Def.</b>			DATE SIGNED <b>June 21 1980</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>			ADDRESS <b>1919 SEMINARY RD., SILVER SPRING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7-24-80</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ALTA VISTA CEMETERY</b>		
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY</b>			ADDRESS <b>ROCKVILLE MD.</b>			25a. REC'D BY REGISTRAR <b>JUL 5 1980</b>		
25b. LOCATION CITY OR TOWN <b>GAINESVILLE</b>			COUNTY <b>GEORGIA</b>			STATE <b>GEORGIA</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frieda Berger Rich</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-29-80</i>		2b. HOUR <i>11 P.M.</i>	
3. SEX <i>Female</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 25 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSP</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Merchant</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Israel Berger</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah (Not Known)</i>		16. SOCIAL SECURITY NO. <i>579-56-2130</i>		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		17b. INFORMANT <i>Mrs. Sylvia Kahn</i>		17c. ADDRESS <i>6013 Summer Hill Road Camp Springs, Maryland</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest etio unknown</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>10 days P.O. Right Mastectomy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>12 days</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Severe depression</i>						
19a. DATE OF OPERATION <i>7-17-80</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Rt. Breast</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>7-17</i> , 19 <i>80</i> , to <i>7-29</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>7-29</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Robert A. Smith</i>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Smith</i>				22e. ADDRESS <i>831 University Blvd S. SS Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/31/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dist. of Col. Lodge Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D. C.</i>		23e. NAME OF FUNERAL DIRECTOR <i>Donald M. Stein</i>				
23f. ADDRESS <i>232 Carroll Street, N. W. Washington, D. C.</i>		23g. DATE REC'D. BY REGISTRAR <i>AUG 6 4 1980</i>		23h. REGISTRAR'S SIGNATURE <i>Robert A. Smith</i>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18670			
1. DECEASED NAME (TYPE OR PRINT) <b>Mildred O. Riggs</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 16 1980</b>		2b. HOUR <b>6:45 AM</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>07 16 80</b>		2d. HOUR <b>6:45 AM</b>	
3. SEX <b>F</b>		4. RACE <b>Blk</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14 1965</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>15 YRS</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>07 16 80</b>		7d. HOUR <b>6:45 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>17608 13 Georgia Ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BOWIE</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET PHOENIX</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-26-2587</b>		17. INFORMANT ADDRESS <b>Percy Riggs - SAME AS ABOVE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4291</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>[Signature]</b>						TITLE (SPECIFY) <b>M.D. Dep.</b>		MEDICAL EXAMINER		DATE SIGNED <b>July 19 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7-19-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Zion, Montg. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b> ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

17-8-1908

THE NATIONAL ANTHROPOLOGICAL ARCHIVES

*[Faint, mostly illegible handwritten text on lined paper, possibly a letter or report. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Eco		MIDDLE W.		LAST Rishell		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 07 24 1980		2b. HOUR 1 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07 27 05		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD July 24 1980		2d. HOUR 1 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6216 Wagner Lane					
14. FATHER'S NAME FIRST MIDDLE LAST Ruff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Cooley				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-56-3314			
17. INFORMANT ADDRESS Hazel Waldron, Sister. Same as item 13.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Cardio Vascular Disease</u> (c) <u>Carcinoma - Left Breast</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Carcinoma - Left Breast</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED July 24 1980							
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd., Beth., Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/29/1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia					
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR JUL 31 1980				25b. REGISTRAR'S SIGNATURE Ruthy...							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15.4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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18672

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES MILTON ROBERTS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 31 80</b>		2b. HOUR <b>6<sup>30</sup> A M</b>	
3. SEX <b>M</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72 years</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>D. C. Govt</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>D. C.</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>6445 Luzon Avenue, N. W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Silas Roberts</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Stated</b>		ADDRESS <b>6445 Luzon Avenue, NW</b>		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-07-8527</b>	17. INFORMANT <b>Shirlee S. Roberts, Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>heart failure</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DOE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DOE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>C/S</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7/21 SW</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> 19 <b>80</b> , to <b>7/31</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/31</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>7/31/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. L. DENNIS</b>		22e. ADDRESS <b>831 UNIV. BLVD. E. SILVER SPRING, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4 Aug 80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P. G. Co., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>W. Ernest Jarvis Co., Inc., Washington, D. C.</b>		ADDRESS <b>1432 You St., NW</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1980</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 7 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE EVELYN ROGERS				2a. DATE OF DEATH MONTH DAY YEAR 07 12 80				2b. HOUR 0445a.m.	
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 03 06 18		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER PROGRAMMER		12b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY Charles		13c. CITY OR TOWN MANJEMOR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RR1 BOX35B	
14. FATHER'S NAME FIRST MIDDLE LAST RANDALL NMN HERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL NMN STOCKSLAGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 214-09-4419		17. INFORMANT ADDRESS WARREN ROGERS RR1 BOX35B MANJEMOR MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). ACUTE BRONCHIAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b). N/A DUE TO, OR AS A CONSEQUENCE OF (c). N/A 485									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.) OAT CELL CARCINOMA OF THE LUNG									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 06 07 80, to 07 12 80, that (I) (we) last saw the deceased alive on 07 12 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.S. BORTHAN				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12 JULY 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. BORTHAN				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-16-80		23c. NAME OF CEMETERY OR CREMATORY HAGERSTOWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN MARYLAND		23e. DATE REC'D. BY REGISTRAR JUL 16 1980	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS BOONESBORO MD.									

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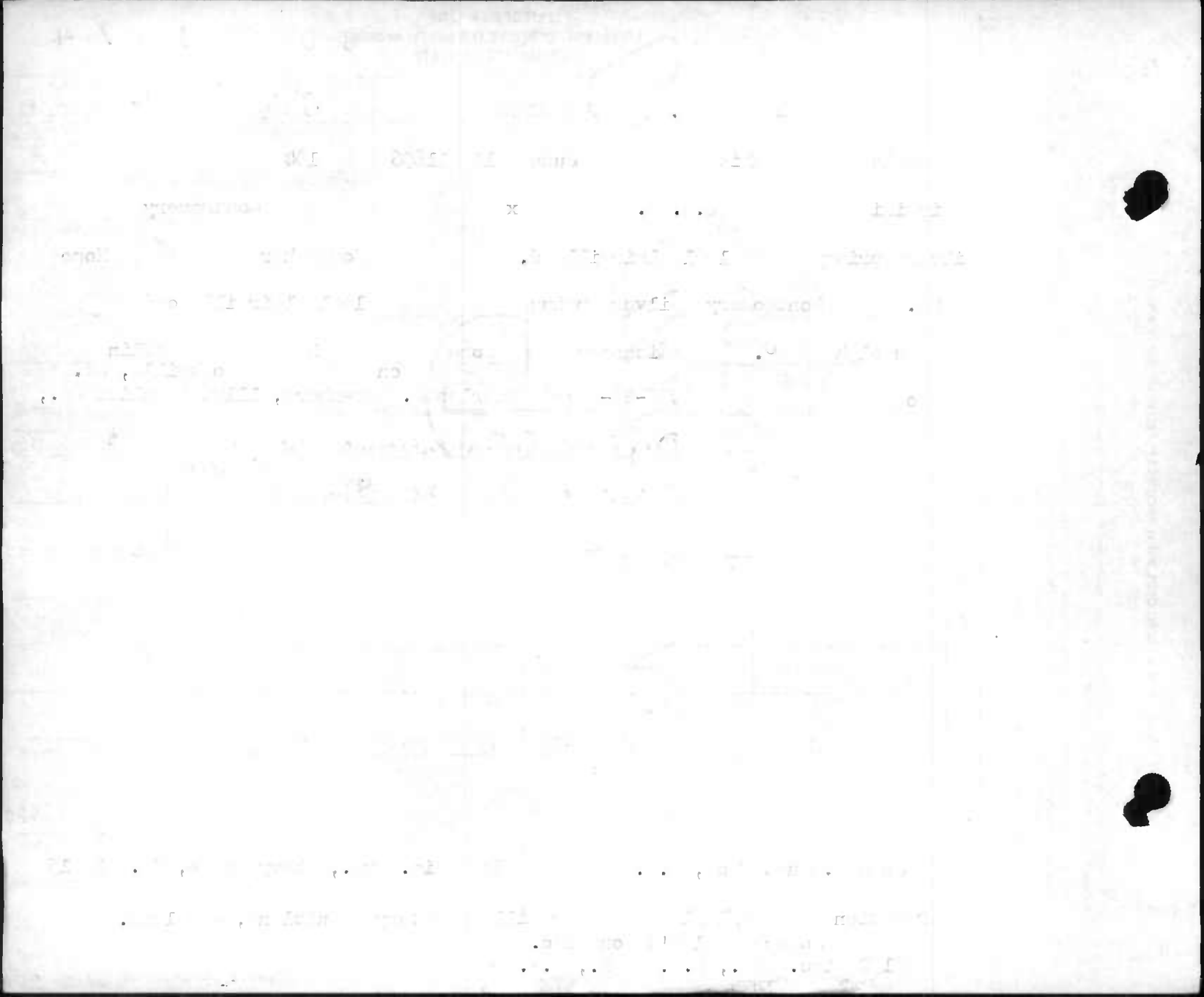


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 1 8 6 7 4	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL E. ROSENBERG</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 12, 1980</b>		2b. HOUR <b>9:02 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1401 Blairmill Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1401 Blairmill Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rudolph C. Eichberg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa M. Heflin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-28-3974</b>		17. INFORMANT Son ADDRESS <b>Rockville, Md.</b> <b>Charles H. Rosenberg, 11106 Marcliff Rd.,</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse Intraabdominal Metastatic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of The Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>1 year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1973</b> , to <b>July 12 1980</b> , that (I) (we) last saw the deceased alive on <b>July 6 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John F. Gustafson</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>July 12, 1980</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Gustafson, M.D.</b>						22e. ADDRESS <b>5480 Wis. Ave., Chevy Chase, Md. 20015</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/14/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland.</b>					
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
24. FUNERAL DIRECTOR ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8018675			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rockie W. Ross				2. DATE OF DEATH MONTH DAY YEAR July 2, 1980			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 1, 1899		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Rockville				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James A. White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 456-20-1138		17. INFORMANT ADDRESS Ima Jewel Weideman, Rockville, MD 20853			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ELECTROLYTE IMBALANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WIDESPREAD METASTATIC CANCER</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST <u>1991</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>DAYS</u> <u>1 YEAR</u>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>80</u> to <u>7/2</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) visit the body after death.							
22b. SIGNATURE <u>Richard Delaney, M.D.</u> DEGREE				22c. DATE SIGNED July 3, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Delaney, M.D.				22e. ADDRESS 4323 Havard Street Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR JUL 11 1980			
				25b. REGISTRAR'S SIGNATURE <u>Harvey McCreedy</u>			

Texas

Rockville

Montgomery

James

to

U. S. A.

A. White

Rockville

XX

Elizabeth

8805 Midway Avenue

grocery

Wilson

4457 Farm Place

488-20-1137 1st Ave, Rockville, MD 20853

July 7, 1980 Parkville, Maryland



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 7 6

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MR. David Harold Roth			2a. DATE OF DEATH MONTH DAY YEAR J 7-7-80			2b. HOUR 9:16 P.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-28-24		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Takoma Park, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Dairy Wine/Higer			
13a. STATE Md			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1220 East West Hwy.		
14. FATHER'S NAME Joseph			MIDDLE Roth		15. MOTHER'S MAIDEN NAME GHA			MIDDLE Slupiro		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 122-16-8904		17. INFORMATION PSN Record			ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 410- DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Centro Lateral Myocardial Infarct (c) Hypertensive + Atherosclerotic C.V. Dis. ? years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hours 30 hours ? years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Peptic Ulcer					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/6 1980, to 7/7 1980, that (I) (we) lost saw the deceased alive on 7/7/80 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Benjamin Isaacson		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Isaacson, M. D.		22e. ADDRESS 7733 ALASKA AVE N.W. WASH. DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-9-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, P. G., Maryland		23e. DATE REC'D. BY REGISTRAR JUL 14 1980			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.		25. REGISTRAR'S SIGNATURE R. J. Brady			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18677

REG. NO.

1 - FOR  
STATE  
REGISTER

1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK W. ROTHAMEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 16 1980</b>			2b. HOUR <b>10<sup>25</sup> AM</b>				
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 16 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRLAND NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>JEWELER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY STORE</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>MONT</b>		13c. CITY OR TOWN <b>SS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <b>14009 CREST HILL LANE</b>										
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERIC SCHENAWISS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE SCHENAWISS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>113-26-8171</b>			17. INFORMANT <b>LILLIAN HOLMES</b>			18. ADDRESS <b>SAME AS ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b>									<b>2 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>BRONCHO PNEUMONIA, Acute, Terminal</b>									<b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>metastatic cancer lungs &amp; skin (back) Primary Pancreas/kidney?</b>										
19a. DATE OF OPERATION <b>(Cancer) 1st detected in Hosp. June 9, 1980</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(Cancer)</b>			20a. AUTOPTICALLY EXAMINED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) <b>—</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1975</b> to <b>July 16, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.										
22b. SIGNATURE <b>John R. Spencer MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7-16-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN R. SPENCER</b>			22e. ADDRESS <b>337 Compton Ave Laurel, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JULY 18, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BROOKLYN NEW YORK</b>		
24. FUNERAL DIRECTOR NAME <b>John J. H.</b>			ADDRESS <b>Laurel, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian Holmes</b>		

MEDICAL CERTIFICATION

11081

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RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

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11081

*[Faint, mostly illegible handwritten text on lined paper, possibly a ledger or record book. The text is written in cursive and spans multiple lines.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 8 6 7 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PP) <b>Louise B. Runnels</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7-11-1980</b>		2b. HOUR <b>9:15 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3-17-99</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10401 Grosvenor Place</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Not Available Miles</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Available</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO <b>578-62-5493</b>		17 INFORMANT ADDRESS <b>9634 Duffer Way</b> <b>Joseph B. Runnels, Gaithersburg, MD</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock</b> <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:10 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/10</b> 19 <b>80</b> , to <b>7/11</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/10</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE <b>E. S. LEVIR</b> M.D.				DEGREE <b>M.D.</b>		27c. DATE SIGNED <b>7/11/80</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDGAR H. LEVIR</b>				27e. ADDRESS <b>8630 Feather St</b> <b>Silver Spring, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7/12/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>	
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> Address <b>Homes, P.A. Bethesda, Maryland</b>				25a. DATE REG'D. BY REGISTRAR <b>JUL 15 1980</b> 25b. REGISTRAR'S SIGNATURE <b>John M. Brady</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING", IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR 15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18679

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Casimir</u> MIDDLE <u>Joseph</u> LAST <u>Rutkowski</u>										2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <u>7 24 1980</u>		2b. HOUR M <u>8:55</u> P					
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>Jul.</u> DAY <u>20</u> YEAR <u>1913</u>		6. AGE (IN YEARS) LAST BIRTHDAY <u>67</u> YRS.		IF UNDER 1 YR. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>		7c. DATE PRONOUNCED DEAD MONTH <u>7</u> DAY <u>26</u> YEAR <u>1980</u>		7d. HOUR M <u>8:55</u> P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Illinois</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>3433 Beret Lane</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Estimator</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Furman Bldr.</u>			
13a. STATE <u>Maryland</u>										13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>4314 Montgomery Avenue</u>	
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u>A.</u> LAST <u>Rutkowski</u>						15. MOTHER'S MAIDEN NAME FIRST <u>Genevieve</u> MIDDLE <u>Galowski</u> LAST <u>Galowski</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u> <u>WWII</u>						16b. SOCIAL SECURITY NO. <u>579-22-6913</u>				17. INFORMANT <u>Step-daughter</u> ADDRESS <u>3433 Beret Lane</u> <u>Rosemary Oxenburg</u> <u>Silver Spring, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>4415</u> IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurism</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Due to, or as a consequence of</u> (c) <u>Due to, or as a consequence of</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET <u>Partial</u> CITY OR TOWN <u>Partial</u> COUNTY <u>Partial</u> STATE <u>Partial</u>									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Hormez R. Guard</u>						TITLE (SPECIFY) <u>Assistant</u> MEDICAL EXAMINER						DATE SIGNED <u>7/27/80</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Hormez R. Guard, M.D.</u>						ADDRESS <u>111 Penn Street, Balto., MD 21201</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Jul. 30, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				23d. LOCATION CITY OR TOWN <u>Arlington</u> COUNTY <u>Va.</u> STATE <u>Va.</u>							
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 30 1980</u>				25b. REGISTRAR'S SIGNATURE <u>History McCreedy</u>							
<u>500 University Blvd., W. Silver Spring, Md.</u>																	

BP

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A21

4514 Lortie and Gosselin

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Researcher's Name: \_\_\_\_\_

2012-01-22

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 6 8 0

REG. NO.

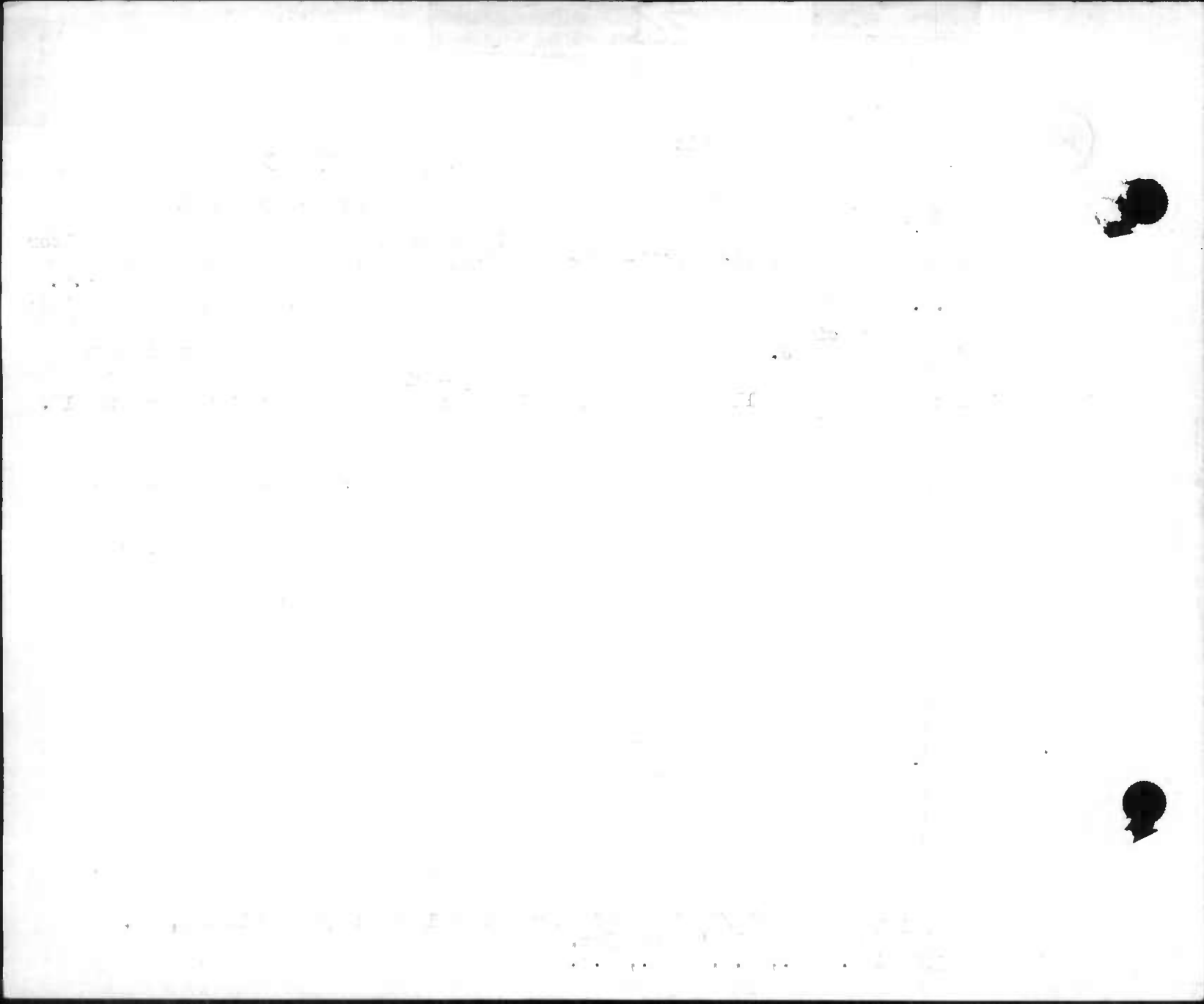
1 DECEASED NAME (TYPE OR PRINT) <b>Victor Sadd</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-19-80</b>			2b. HOUR <b>8:00 P.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 24 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill-Bethesda Lane</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NAVY Comdr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Realtor Social Security N.W.</b>	
13a STATE <b>D.C.</b>		13b COUNTY <b>Wash, Dc</b>		13c CITY OR TOWN <b>Wash, Dc</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3027 Normanstone Terrace</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank J. Sadd</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Bullingham</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					
16b SOCIAL SECURITY NO. <b>578-14-999</b>		17 INFORMANT <b>Marie C Sadd</b>		18 ADDRESS <b>Same as Item 13.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF <b>OF THE PROSTATE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>JULY 10 19 80</b> to <b>JULY 17 19 80</b> , that (1) (we) last saw the deceased alive on <b>JULY 10 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>R.C. Daddario MD</b>						DEGREE <b>MD</b>		22c DATE SIGNED <b>7/19/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT C. DADDARIO MD</b>						22e ADDRESS <b>5413 CEDAR LANE BETHESDA</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/23/1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va MD.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.</b>						25a. DATE RECEIVED BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL, ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



4308 Released by Dr. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

18681

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Agripino c. San Jose, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 22 80</i>			2b. HOUR <i>3:40 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>Filipino</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 21 1933</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>46</i> YRS		7. UNDER 1 YEAR MONTHS DAYS <i>46</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Phillipines</i>	7b. CITIZEN OF WHAT COUNTRY? <i>Phillipines</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Mortgage</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>7508 Glenriddle Road</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Agripino C. San Jose</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Purification Cocjin</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>579-96-7507</i>		17. INFORMANT ADDRESS <i>Pilar J. San Jose (Same as 13e)</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute posterior myocardial infarct</i>		<i>36 hr</i>
	DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary sclerosis</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>July 22 1980</i> to <i>July 22 1980</i> , that (1) (we) last saw the deceased alive on <i>July 22 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <i>Morton W. Shapiro</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>7/23/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Morton W. Shapiro, M.D.</i>				22e. ADDRESS <i>5225 Pooks H. II Rd Beth Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>7-25-80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Md.</i>
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 29 1980</i>	25b. REGISTRAR'S SIGNATURE <i>Pietro K. Kretzky</i>

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS FORESEEN, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 8 6 8 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELENI G. SANTAS</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>JULY 9 19 80</b>		2b. HOUR <b>2:26PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		7c. DATE PRONOUNCED DEAD <b>JULY 9 19 80 2:26PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GREECE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>GREECE</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9534 RILEY ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>PETROS GLENIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHRISOULA KTENAS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>JOHN BORSAS SAME AS 13 SON-IN-LAW</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC MYOCARDIAL DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>NONE</b>											
19a. DATE OF OPERATION <b>NONE</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>JULY 9, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>				ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/11/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Kathy Melroy</i>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18683

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Leroy T. Sargood Jr.</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7-10-1980</b>		2b. HOUR <b>12:40 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1-27-56</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>24</b> YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>July 10 1980</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shipper - Bakery -</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>	13b. CITY OR TOWN <b>Pr. Geo.</b>	13c. STREET ADDRESS <b>Laurel</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>13305 - Edinburgh Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leroy T. Sargood Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara DeSoucey</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>Vietnam</b>		17. INFORMANT <b>Ruth M. Sargood (above address)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries Severe -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pedestrian - Auto. Trauma.</b> (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>9:30 P.M. 7-9 1980</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Struck by Auto when pulling out from parking space.</b>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>495 Route 1 near New Hamp Ave - Silver Spring Mont. Md.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>John M. Ball</b>		TITLE (SPECIFY) M.D. <b>Deputy</b>		MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7/12/1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>
24. FUNERAL DIRECTOR NAME <b>Nalley's E.H.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 16 1980</b>		25b. REGISTRAR'S SIGNATURE

DATE SIGNED **July 10, 1980**

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth E. Sauber			2a. DATE OF DEATH MONTH DAY YEAR July 23, 1980		2b. HOUR 315 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 10 1902		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY -----						

13a. STATE Maryland			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7408 Haddington Place	
14. FATHER'S NAME FIRST MIDDLE LAST Simon --- Friedman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna --- Blajwas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 578-58-7885			17. INFORMANT ADDRESS Frank Sauber; 6908 Breezewood Terr, Rockville Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 3352 DUE TO, OR AS A CONSEQUENCE OF (b) Amygdalic / lateral sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7-14-80 7-23 19 80			
22a. I certify that (I) (this hospital) attended the deceased from 7-23-80, to 7-23-80, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carroll D. Mahony				22c. DATE SIGNED 7-23-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARROLL D. MAHONY, M.D.				22e. ADDRESS 10301 Georgia Ave., SSpG, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-80		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS DanZansky-Goldberg Chapels 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR JUL 28 1980			



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The following" and "is" are faintly visible.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 8 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SAWHLA MAUNG			2a. DATE OF DEATH MONTH DAY YEAR 7-17-80			2b. HOUR 1:30A				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Burma		7c. CITIZEN OF WHAT COUNTRY? Burma		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 206 Taylor Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Bo Yik Dawu			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dawu							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS Phan Ton-Same as #13 Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure & Carcinoma 1550 DUE TO, OR AS A CONSEQUENCE OF (b) Hepatocellular Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/13 19 80 to 7/17 19 80, that (I) (we) lost saw the deceased alive on July 17 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Boo K. Kim			DEGREE MD			22c. DATE SIGNED July 17, 1980		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim		
22e. ADDRESS 16220 Frederic Rd, Edith, Md			22f. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 7-17-80			23c. NAME OF CEMETERY OR CREMATORY George Washington Medical School			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service			24b. ADDRESS 5517 Vine Street Alexandria, Va.			25a. DATE REC'D. BY REGISTRAR JUL 22 1980		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



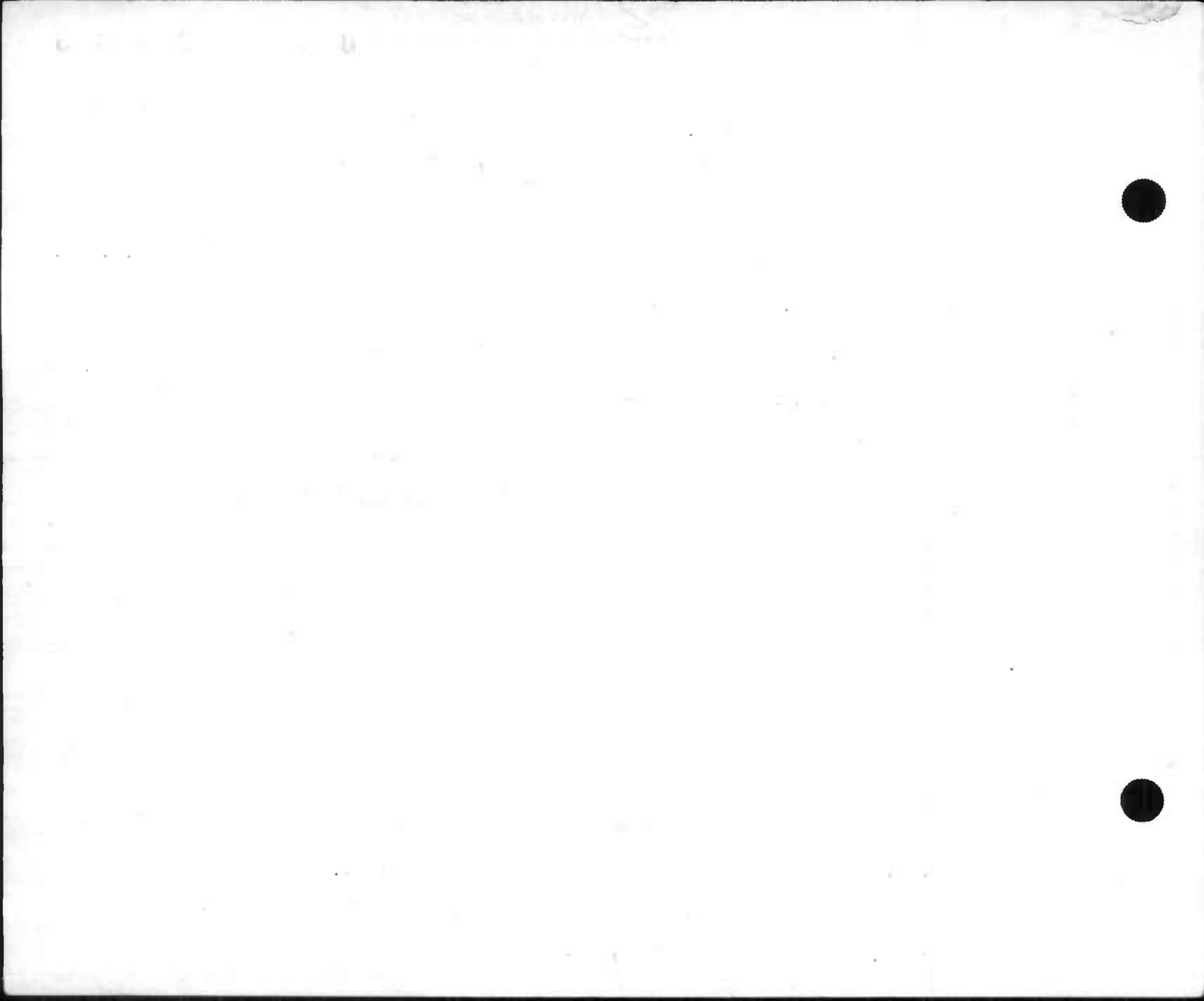


1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Dean Schamberger SR.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7-11-80</b>		2b. HOUR <b>10:30 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 16, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nuclear Physicist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>26 Goshen Court</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sanford O. Schamberger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eldora - Hodder</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>	16c. SOCIAL SECURITY NO <b>068-18-3917</b>	17. INFORMANT <b>Shirley Schamberger</b> ADDRESS <b>Same as # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, diffuse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Thrombocytopenia, subdural hematoma, cerebral aneurysm</b>					
19a. DATE OF OPERATION <b>3-20-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive jaundice</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>6/25</b> 19 <b>80</b> to <b>7/11</b> 19 <b>80</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>7/11/80</b> 19 <b>80</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> (do not) view the body after death.					
22b. SIGNATURE <b>Robert Birschbach</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>7/11/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. Robert Birschbach</b>				22e. ADDRESS <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 12, 1980</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis H. Barber Laytonsville, Md. 20760</b>				25a. DATE RECEIVED BY REGISTRAR <b>JUL 15 1980</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISAAC SCHATZ			2a. DATE OF DEATH MONTH DAY YEAR July 11/1980		2b. HOUR 2 P.M.								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer		12b. KIND OF BUSINESS OR INDUSTRY Liquor Store					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9109 Brierly Road	
14. FATHER'S NAME FIRST MIDDLE LAST Leon --- Schatz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie (unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-22-2957A		17. INFORMANT ADDRESS Theodore Schatz, 9109 Brierly Rd, Ch Ch, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral shock</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11-12 da.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Arteriosclerosis brain disease;</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/30/80</u> 19 <u>80</u> to <u>7/11/80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/11/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Bernard J. Walsh</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>7/11/80</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD J. WALSH, M.D.						22e. ADDRESS 1800 Eye Street N.W., Wash., D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 13, 1980			23c. NAME OF CEMETERY OR CREMATORY D. C. Lodge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.				
24. FUNERAL DIRECTOR NAME Danansky-Goldberg Chapels, 1170 Rockville Pike						25a. DATE REC'D. BY REGISTRAR JUL 15 1980			25b. REGISTRAR'S SIGNATURE				

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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*[The body of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or letter, possibly detailing agricultural matters.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CLARA M. SCHMIECH</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 13, 1980</b>			2b HOUR <b>7:45A M</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 16 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>7 13 45</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>				
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Rockville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>259 Congressional Lane</b>	
14 FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Marshall</b> LAST <b>Marshall</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b>Maguire</b> LAST <b>Maguire</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>578-68-7761</b>		17 INFORMANT <b>Robert M. Schmiech</b>		ADDRESS <b>3810 Palmira Lane Silver Spring, Md.</b>				
18 CAUSE OF DEATH: Enter only one cause (see instructions on back of form). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE: <b>Acute myocardial infarction</b> <b>4-10-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>5 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>Sudden</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/7 1980</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <b>7/7</b> to <b>7/13</b> 19 <b>80</b> , that (1) (two) most saw the deceased alive on <b>7/13</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (two) (did/did not) see the body after death.										
22b SIGNATURE <b>Myron L. Lenkin</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>7/13/80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>			22e ADDRESS <b>23095 HOREFIELD RD, WHEATON, MD</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>7/16/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home</b>			1331 Rockville Pike <b>Rockville, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 16 1980</b>		25b REGISTRAR'S SIGNATURE <b>Myron L. Lenkin</b>			

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July 13, 1931

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18589	
1. DECEASED NAME (TYPE OR PRINT) <b>Karl GEORG Schwarze</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 18, 1980</b>		2b. HOUR <b>2:45 P.M.</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 24, 1929</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>51</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>July 18, 1980</b>	2d. HOUR <b>2:45 P.M.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Sil. Spg.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED ORNAM. IRON WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Sil. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>601 Cirt Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>KARL SCHWARZE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNE DIETZEL</b>			16. ADDRESS <b>(SAME AS #13)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-074183A</b>			17. INFORMANT <b>MARIE L. SCHWARZE ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4409 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis 4ro.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>			TITLE (SPECIFY) <b>M.D. Dep.</b>			MEDICAL EXAMINER		DATE SIGNED <b>July 8, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
23a. CREMATION, REMOVAL, OR OTHER (SPECIFY) <b>CREMATION</b>			23b. DATE <b>July 19, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brownwood P.D. MD</b>				
24. FUNERAL DIRECTOR NAME <b>Takara Funeral Home, Inc.</b>			ADDRESS <b>284 Carroll St. N.W. DC</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUL 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

18000

RECEIVED  
U.S.A.  
STREET 11300 MARIE L. SCHWARZ  
APR 19 1964

RECEIVED  
U.S.A.  
STREET 11300 MARIE L. SCHWARZ  
APR 19 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN BETY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 14 80</b>		2b. HOUR <b>5:20 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DECEMBER 25, 1893</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>86</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>86</b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9c. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CABINET MAKER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE</b>		13a. STREET ADDRESS <b>8505 SPRINGVALE ROAD</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS SEGAL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>YETTA LESNICK</b>		16. SOCIAL SECURITY NO. <b>579-36-1178</b>	
17. INFORMANT ADDRESS <b>BETHESDA, MARYLAND</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b> <b>3300</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension, ASCAD, recurrent volvulus, chronic aspiratory pneum, seizures</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/6</b> , 19 <b>68</b> to <b>7/14</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>7/14</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4) <input type="checkbox"/> (5) <input type="checkbox"/> (6) <input type="checkbox"/> (7) <input type="checkbox"/> (8) <input type="checkbox"/> (9) <input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> (14) <input type="checkbox"/> (15) <input type="checkbox"/> (16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/> (19) <input type="checkbox"/> (20) <input type="checkbox"/> (21) 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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

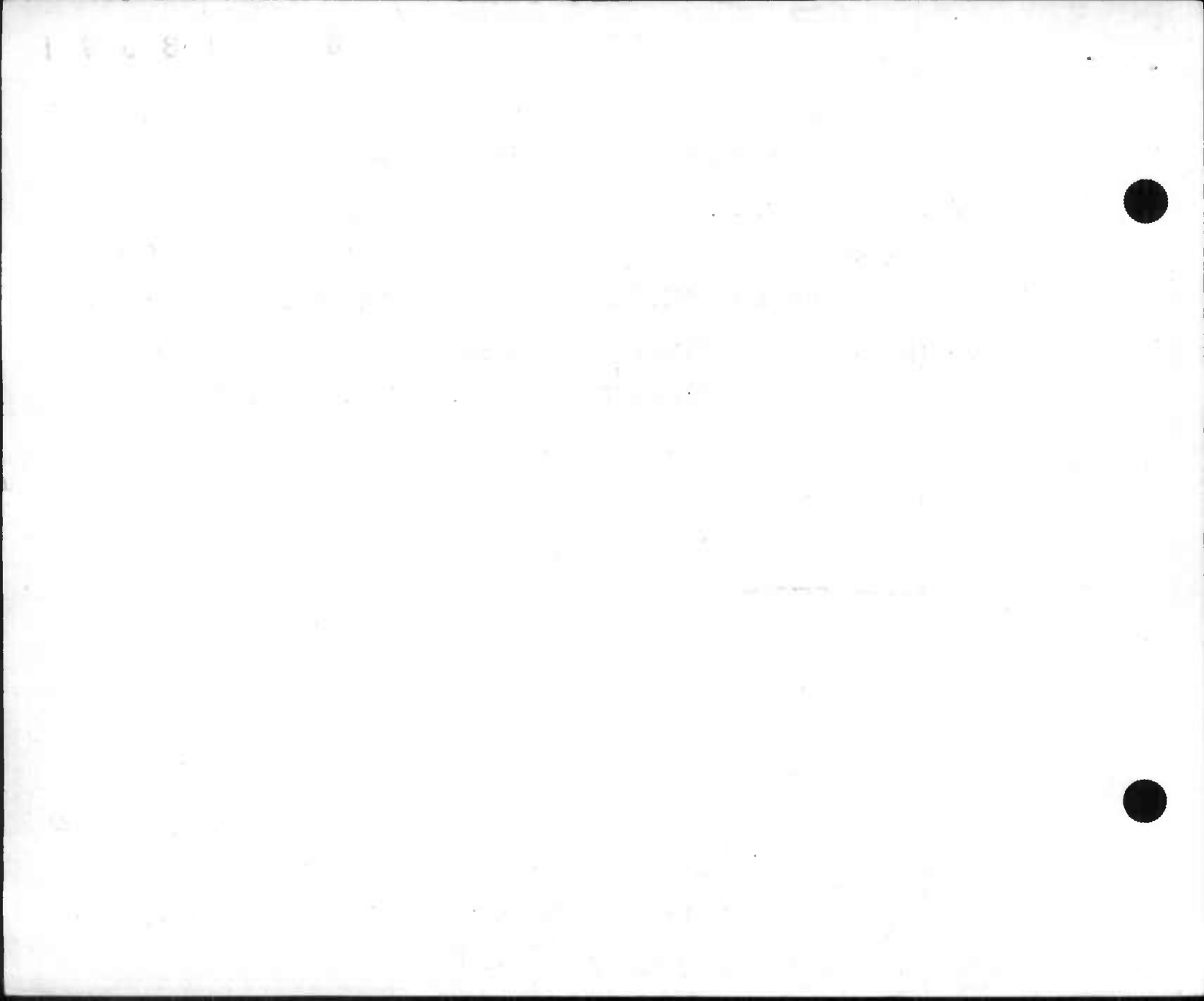
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 9 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rose A Segraves</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 14 80</i>		2b. HOUR <i>8 45 PM</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 17 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED BEAUTY</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SHOP OWNER</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MARYLAND</i>		13c. CITY OR TOWN <i>MONTGOMERY</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>19307 CLUB HOUSE ROAD #202</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Franklin Allred</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Nestor</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>577-24-9792</i>		17. INFORMANT ADDRESS <i>JAMES H. Segraves (SAME AS 13e)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>3314</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Probable Pulmonary Embolism</i> (c) <i>S/p op. for Ventricle-peritoneal shunt</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Normal Pressure Hydrocephalus</i>						
19a. DATE OF OPERATION <i>7/14</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Normal Pressure Hydrocephalus</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3 11 80</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11119 Rockville Pike suite 502</i>		
22a. I certify that (i) this hospital attended the deceased from <i>7/14</i> , 19 <i>80</i> , to <i>7/14</i> , 19 <i>80</i> , and that in my (hour) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) sew the body after death.						
22b. SIGNATURE <i>Robert A. Pumphrey</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>7/15/80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Pumphrey</i>		22e. ADDRESS <i>11119 Rockville Pike suite 502</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JULY 18, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCKVILLE CEMETERY</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROCKVILLE MONTGOMERY MD.</i>		23e. DATE REC'D. BY REGISTRAR <i>JUL 23 1980</i>				
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES P/A</i>		24b. ADDRESS <i>ROCKVILLE, MARYLAND</i>				
24c. DATE REC'D. BY REGISTRAR <i>JUL 23 1980</i>		24d. REGISTRAR'S SIGNATURE <i>[Signature]</i>				





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8018692	
1. DECEASED NAME (TYPE OR PRINT) Benjamin A. Shaw, Sr.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2b. HOUR 9:55 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH 11 8 1899		6. AGE (IN YEARS) 80	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD July 20, 1980		24 HOUR PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,			
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10408 Amber Ave.			
14. FATHER'S NAME George F. Shaw				15. MOTHER'S MAIDEN NAME (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES) WW 11		16b. SOCIAL SECURITY NO. 220-44-3085		17. INFORMANT Daughter, Barbara S. Elliott		ADDRESS 7307 Wildwood Dr. Pk. Pk.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Myocardial Dis. 4 yrs. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, DME		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED July 21, 1980					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-24-1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN Rockville		COUNTY Montgomery		STATE Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE							

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Item #8 Film G546 8/22/80 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 9 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) C. Russell Shetterly			2r. DATE OF DEATH MONTH DAY YEAR July 21, 1980			2b. HOUR 2:10 A M	
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS	7 UNDER 1 YEAR MONTHS DAYS		7b. UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Colorado	13b. COUNTY Denver	13c. CITY OR TOWN Denver	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 650 South Alton Way		
14. FATHER'S NAME FIRST Charles MIDDLE Joseph LAST Shetterly			15. MOTHER'S MAIDEN NAME FIRST Charlotte MIDDLE Gardner LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17 INFORMANT ADDRESS 4707 Broad Brook Dr. Bethesda, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:410-  
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Congestive heart failure  
Myocardial infarction  
Atherosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

few hours  
9 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none to		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) none			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from July 12, 1980, to July 19, 1980, that (1) (we) last saw the deceased alive on July 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allen J. O'Neill				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 18, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. O'Neill				22e. ADDRESS 8601 Old Georgetown Rd. Bethesda, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 24, 1980	23c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Denver, Colorado
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., BETHESDA, MARYLAND			25a. DATE REC'D. BY REGISTRAR AUG 18 1980

TO HOSPITALS AND ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Patent seen in my office by Mrs. S. Hantel

See file # 410-12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8018694

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
IDA R. SILVERSMITH		July 30, 1980		8:00 pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	68 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Russia	USA		Montgomery MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Chevy Chase	5480 Wisconsin Avenue	Clerk (Ret)	U.S. Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?	13b. STREET ADDRESS		
13a. STATE	13b. COUNTY	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5480 Wisconsin Avenue		
Maryland	Montgomery				
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Benjamin Reznick		Sarah Sosnick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		156-03-6973		David Reznick; 12103 Greenleaf Ave., Potomac, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest -</u> 4149 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7:30</u> <u>1980</u> , to <u>7:28</u> <u>1980</u> , that (I) (we) lost saw the deceased alive on <u>7:30</u> <u>1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Bernardo Kotelanski</u>		22c. DATE SIGNED July 30, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Bernardo Kotelanski		4301 Mass. Ave. N.W. # 1002 Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	Aug 1, 1980	Beth Sholom Cem.	Capitol Heights, Maryland		
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
DANZANSKY-GOLDBERG CHAPELS		AUG 5 1980			

49281 08



000 230A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 8 6 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Celia T. Simpson				2a. DATE OF DEATH MONTH DAY YEAR 7 - 5 - 1980			
3 SEX Female				2b. HOUR 11 <sup>15</sup> AM			
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7 UNDER 1 YEAR MONTHS DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7c. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery			
13c. CITY OR TOWN Kensington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST John McMahon				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary King			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-52-6705		17 INFORMANT ADDRESS Kenneth W. Simpson, Jr., Bethesda, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410 - DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 26</u> , 19 <u>80</u> , to <u>July 5</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Barry Helms</u> MD				DEGREE MD		22c. DATE SIGNED July 5, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HELMS				22e. ADDRESS 10620 GEORGIA AVENUE Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 14 1980		25b. REGISTRAR'S SIGNATURE <u>Barry Helms</u>	

1803

CECEA

1. 1900

Female

Caucasian

Dec. 22, 1900

New York

U. S. A.

X

Holy Cross Hospital

Clark

Dept. Store

Maryland

Montgomery Kensington

X

10422 Fairview Street

John

McMahon

Mary

King

8910 Saunders Lane  
Bethesda, Maryland

Dr. Kenneth J. Simpson, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 6 9 6			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Mary</b>		MIDDLE <b>A</b>		LAST <b>Sioris</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>07 25 80</b>			2b. HOUR MIN <b>2:30AM</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 9, 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10 CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hosp. Olney Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont. Co.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1110 Fidlers Lane</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred - Burton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine - Condon</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17 INFORMANT <b>Catherine Roe (Daughter) Same as # 13.</b>									
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular event.</b> <b>4839</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA/CHF/Hypothyroidism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Failure, IHD</b>										SAP (APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH) <b>7/25/80</b> <b>6/86/80</b> <b>6/16/80</b>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>No</b>													
18a. DATE OF OPERATION <b>None</b>		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>				19a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>									
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE ON TRIP <input type="checkbox"/> <b>N/A</b>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OUT OF TOWN, ETC.) <b>N/A</b>		21c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/10/80</b> to <b>7/25</b> 19 <b>80</b>									
22. I certify that (I) (the hospital) attended the deceased from <b>6/10/80</b> to <b>7/25</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/24</b> 19 <b>80</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If the funeral director did not view the body after death, so state.)													
22a. SIGNATURE <b>A. Schenck</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED <b>7/25/80</b>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Schenck</b>		22d. ADDRESS <b>Montgomery Gen Hospital</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morningside Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dubois, Clearfield Co., Pa.</b>							
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home</b>		ADDRESS <b>Silver Spring, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 04 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. ...</b>							

March 2 1943

Dear Mr. [illegible]

I have received your letter of the 2nd inst.

and am sorry that I cannot give you a more definite answer at this time.

The matter is being considered and I will let you know as soon as a decision has been reached.

Very truly yours,

[illegible signature]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

18697

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John SKIBIAK			2a. DATE OF DEATH MONTH DAY YEAR July 7 1980			2b. HOUR 1119 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Fairfax		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 209 Patrick Street, S.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Alex Skibiak				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anastasia Slota						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-60		17. INFORMANT Mrs. Beatrice M. Skibiak				ADDRESS See item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 30</u> , 19 <u>80</u> , to <u>July 7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> , 19 <u>80</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George T. Gamblin</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED July 8, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George T. Gamblin, M.D.					22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-11-80		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME Money & King Funeral Home					ADDRESS Vienna, Va.		25a. DATE REC'D. BY REGISTRAR JUL 14 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>	

BP

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 6 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM J. SLATTERY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 6 80</b>			2b. HOUR <b>7:15 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 25, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LIBRARIAN</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>NATL BUR. OF STAN</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1723 DUBLIN DRIVE</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES A. SLATTERY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CELINA GANNON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>578-42-9639</b>		17. INFORMANT <b>MARIE C. SLATTERY</b>		ADDRESS <b>SAME AS 13</b>	
						<b>WIFE</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic myelocytic leukemia, accelerated phase</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with leukemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>less than 1 hr.</b> <b>more than 1 year</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30</b> 19 <b>80</b> to <b>7/6</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/5/80</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Deborah B Goldberg</b> MD		22c. DATE SIGNED <b>7/7/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Deborah B Goldberg</b>		22e. ADDRESS <b>1100 Spring St, Silver Spring Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/9/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Kennedy</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



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Add. Info. Film 546 8/19/80 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 18699

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sophia Cooper Sloan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 22/1980</i>		2b. HOUR <i>9:55 PM</i>
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1/19/05</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	
13a. STATE <i>North Carolina</i>	13b. COUNTY <i>Greensboro</i>	13c. CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	13d. STREET ADDRESS <i>802 B Marsh Street</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Loren Earl Sloan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jane Cooper</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>239-22-9791</i>	17. INFORMANT <i>11700 Old Columbia Pike, MD</i> <i>Juanita Sloan (daughter) Silver Spring</i>			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Artery</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
411- CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Global Subendocardial Ischemia</i>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Upper GI bleeding @ Mild dehydration @ Respiratory arrest</i>			
19a. DATE OF OPERATION <i>0</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>e</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>6</i> 19 <i>80</i> to <i>7-22</i> 19 <i>80</i> , that (1) (we) last saw the deceased alive on <i>7-22-80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Charles Franklin Jr</i>		DEGREE <i>MD</i>	22c. DATE SIGNED <i>7-22-80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles Franklin Jr</i>		22e. ADDRESS <i>11200 Rockwood Dr Silver Spring Md 20901</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>7/27/80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Maplewood Cem. Park</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Greensboro, North Carolina</i>
24. FUNERAL DIRECTOR NAME <i>LATNEY FUNERAL HOME</i>		25. DATE REC'D. BY REGISTRAR <i>JUL 24 1980</i>	
26. ADDRESS <i>3831 GA AVE. NW WASH. DC</i>		27. REGISTRAR'S SIGNATURE <i>John McCreedy</i>	
28. ADDRESS <i>HARGETT F.H. 905-E MARKET ST. GREENSBORO NC</i>			

BP

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(VRA 15, 4) 1/79

1981-82

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is followed by a detailed account of the work done in each of the various departments and sections. The report then goes on to discuss the results of the work and the progress made towards the completion of the various projects. Finally, it concludes with a summary of the work done and a statement of the progress made.

2. The second part of the report deals with the financial statement of the organization. It gives a detailed account of the income and expenditure for the year and shows the balance sheet at the end of the year. It also includes a statement of the assets and liabilities of the organization.

3. The third part of the report deals with the personnel statement. It gives a detailed account of the staff of the organization and shows the progress made in the recruitment and training of new staff. It also includes a statement of the salaries and allowances paid to the staff.

4. The fourth part of the report deals with the general remarks of the management. It gives a detailed account of the various projects and schemes undertaken by the organization and shows the progress made in their completion. It also includes a statement of the various difficulties encountered and the steps taken to overcome them.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 8 7 0 0

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7b. DATE KNOWN OF DEATH ESTIMATED		7b. HOUR	
Marie Elizabeth Smedley				7/28 1980		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
Female	White	Jan. 16, 1922	58 YRS.			7/28 1980	10:20 P. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
New Jersey	U. S. A.				Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney	3212 Spartan Road, #34		Housewife Own Home				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Olney	YES <input type="checkbox"/> NO <input type="checkbox"/>	Spartan Rd. 3212 Spartan Road, #34			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT			
Andrew McKelvey McIntrye		Sarah Burke		3212 Spartan Rd. Olney, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		064-16-3018		David Smedley			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>carcinoma of the breast.</u>							2 yrs.
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR		None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
John S. Rogers, M.D.		Deputy		1919 Seminary Road Silver Spring, Montgomery, Md.		7/29/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7/31/80		Gate of Heaven Cemetery		Silver Spring, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc., Sil. Spr., Md.		AUG 04 1980		Linton McCreedy			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

18701

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST ALLEN		MIDDLE R.		LAST SNOWDEN		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7 18 19 80		2b. HOUR M					
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR April 2, 1954		6. AGE (IN YEARS) (LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 7 21 19 80		2d. HOUR 4:30 M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (creek) South Lane & Incinerator Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Apprentice electrician		12b. KIND OF BUSINESS OR INDUSTRY electric contractor							
13a. STATE Md				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 300 Woodland Road			
14. FATHER'S NAME FIRST MIDDLE LAST Allen Roy Snowden						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JoAnn Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 66 7995		17. INFORMANT JoAnn Proffitt		ADDRESS 1653 New Windsor Ct Crofton, Md 21114									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9688 IMMEDIATE CAUSE (a) Blunt force injuries of the head DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7-18-19 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject beaten.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) creek				21f. LOCATION STREET South Lane & Incinerator Dr.		CITY OR TOWN Rockville		COUNTY Montgomery		STATE Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 7-22-80			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Lutheran Cem				23d. LOCATION CITY OR TOWN Brickerville, Pa				COUNTY STATE	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md				25a. DATE REC'D. BY REGISTRAR JUL 30 1980				25b. REGISTRAR'S SIGNATURE 							

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100-81080

April 2, 1980

Washington, D.C.

300 Woodland Road  
Baltimore, MD 21204

Post Office

John Smith

John Smith

100 New Windsor Ct  
Baltimore, MD 21204

John Smith

100 New Windsor Ct

cc

July 2, 1980

cc

July 2, 1980

John Smith



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MAY BUSHALL SOUDER</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>10</b> YEAR <b>80</b>		2b. HOUR <b>9 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>23</b> YEAR <b>1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9127 Georgia Avenue,</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Sil. Spring</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>9127 Georgia Avenue,</b>		
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>H.</b> LAST <b>Bushall</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Hansell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-50-9004</b>		17. INFORMANT (daughter) ADDRESS <b>Margaret J. Souder (same as 13e)</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized arteriosclerosis</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>stroke with rt hemiplegia - remote</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 65</b> , to <b>7-10 80</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>7-9 80</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <b>G. Sengstack MD.</b>		DEGREE		22c. DATE SIGNED <b>7-10-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Sengstack, MD</b>		22e. ADDRESS <b>9241 Columbia Blvd., S.S. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-12-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery, Washington, DC</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECEIVED BY REGISTRAR <b>JUL 15 1980</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ESTABLISHED 1870  
STATIONER & PRINTER  
175 N. 3rd St. St. Paul, Minn.

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PAID RUSSELL 2nd 5-10-80 99

Handwritten notes and ledger entries, including a table with columns for dates and amounts.

Handwritten notes and ledger entries, including a table with columns for dates and amounts.

Handwritten notes and ledger entries, including a table with columns for dates and amounts.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna Sowin</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>7 27 80</i>			2b. HOUR MIN. <i>757 P</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 2 1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>80</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 4 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7c. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retail Store</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Md. Montgomery Sil. Spr.</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1705 Cody Drive</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Anthony Kerevlis</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>043-20-2435</i>		17. INFORMANT ADDRESS <i>Anthony Rovillard 1705 Cody Drive Sil. Spr., Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Aspiration; Hypotensive Shock Recurrent Tumors (Ovary)</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/27</i> 19 <i>80</i> , to <i>7/27</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/27/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Antonio G. Uy</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>7/28/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. UY</i>				22e. ADDRESS <i>831 Univ. Blvd E #25 Silver Spring, Md 20903</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/1/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Shady Lane Cemetery Chinchella,</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pa.</i>		
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Ga. Ave. Sil. Spr., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 04 1980</i>		25b. REGISTRAR'S SIGNATURE <i>History/Rebuddy</i>			

13300

Handwritten notes and a faint grid structure, possibly a ledger or form, with illegible entries.

Handwritten text, possibly a title or header, which is mostly illegible.

Handwritten text and numbers, including what appears to be a date "4/28/81" and other numerical figures.

Handwritten text at the bottom left, possibly a signature or date.

Handwritten text at the bottom right, possibly a signature or name.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 8 7 0 4  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Albert Arthur Stanley</b>			2a. DATE OF DEATH <b>July 29 1980</b>		2b. HOUR <b>5:15 PM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Dec. 1, 1906</b>		6. AGE (In years last birthday) <b>73</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>509 Springlock Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Civil Engineer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
14. FATHER'S NAME First <b>Herbert</b> Middle <b>A.</b> Last <b>Stanley</b>		15. MOTHER'S MAIDEN NAME First <b>Lena</b> Middle <b>L.</b> Last <b>Comer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov. employee</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220-42-2938</b>		17. INFORMANT <b>wife</b> Address <b>same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive arteriosclerotic cardiovascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>33 days</b> <b>10 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Parkinsons Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1977</b> to <b>July 29, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 29, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Raymond Bradshaw Jr. MD</b> DEGREE <b>MD</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw Jr.</b>				22e. ADDRESS <b>345 University Blvd, W. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
24. FUNERAL DIRECTOR <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>JUL 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John McLean</b>	
500 University Blvd., W. Silver Spring, Md.		23d. LOCATION (City or Town) <b>Silver Spring</b> (County) <b>Mont.</b> (State) <b>Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Alfred Arthur Stanley, Jr.

Male, born [illegible] New York City

Residence [illegible]

Occupation [illegible]

Married [illegible]

Education [illegible]

Religion [illegible]

Signature of [illegible]

Date [illegible]

Place [illegible]

Signature of [illegible]

Date [illegible]

Place [illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		8 0 1 8 7 0 5									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Alfred Eric Steck						2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Apr. 5, 1953		6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 20 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conservator		12b. KIND OF BUSINESS OR INDUSTRY Smithsonian Inst.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 75 E. Wayne Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conservator		12b. KIND OF BUSINESS OR INDUSTRY Smithsonian Inst.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 75 E. Wayne Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Edgar A. Steck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Anselment							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) elevator Apt Bldg		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Edgar Steck-1913 Edgewater Pkwy S.S. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of chest</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:15 PM 7/20 19 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) elevator Apt Bldg				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 75 E. Wayne Avenue, Silver Spring, MontCo., MD			
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER		DATE SIGNED 7/21/80			
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.				ADDRESS		111 Penn Street, Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/22/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C. 20016						25a. DATE REC'D. BY REGISTRAR JUL 24 1980		25b. REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 7 0 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT LOUIS STEIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1980</b>		2b. HOUR <b>2:45am</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 22, 1926</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Commissioner Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8607 Victory Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sara Sulzberger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17 INFORMANT ADDRESS <b>Judith Stein; 8607 Victory Lane, Potomac, Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Large Bowel</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>26RS</b> <b>6 mos</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19 79</b> , to <b>7-26</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7-25</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Herbert L. Tanenbaum</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-28-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Herbert L. Tanenbaum, M.D.</b>				22e. ADDRESS <b>5480 Wisconsin Avenue, Chevy Chase, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensburg, Maryland</b>					
24 FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels;</b>				ADDRESS <b>1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

008108



*Handwritten signature or initials*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 8 7 0 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET STOCKLINSKI			2a. DATE OF DEATH MONTH DAY YEAR 7 5 80		2b. HOUR 0600 AM
3 SEX FEMALE	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR JUNE 15 1924	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10 CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	12b. KIND OF BUSINESS OR INDUSTRY GRADE SCHOOL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN DARNESTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 15613 JONES LANE	
14 FATHER'S NAME FIRST MIDDLE LAST MANUEL FRATES			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET (NOT AVAIL.)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO		16b. SOCIAL SECURITY NO. 024-14-2102	17 INFORMANT ADDRESS EDWARD I. STOCKLINSKI (SAME AS 13e)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac standstill DUE TO, OR AS A CONSEQUENCE OF (b) hypoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary edema					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 4 days 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-1 19 80, to 7-5 19 80, that (I) (we) lost saw the deceased alive on 7-5 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas G. Sinderson, MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-5-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD			22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD. 20852		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 8, 1980	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BARNESVILLE MONTGOMERY MD.		
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A			25a. DATE REC'D BY REGISTRAR JUL 14 1980		
300 W. MONTGOMERY AVE., ROCKVILLE, MD.					

1818

MANUEL  
FRANKS  
EDWARD T. STOCKHART (SAR 42-116)  
MARGARET  
1925 DATES LA E  
TEACHER  
GRADE SCHOOL

JOHN A. HUNTER, JR., ROCHESTER, N.Y.  
JULY 8, 1963, ST. MARY'S CHURCH, ROCHESTER, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8018708

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7-21-80		4 <sup>55</sup> P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUCASIAN		MONTH DAY YEAR		79 YRS.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
KANSAS		USA				Montgomery County, MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		EDITOR		NEWSPAPER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONT.		KENSINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		3506 KENT ST. 20795			
CLAREYCE A. STODARD		ANNA CHATFIELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
No		509-22-6529		JEAN S. BUTTON - ITEMS # 13		SAME AS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY							Immediate
IMMEDIATE CAUSE (a) Respiratory arrest							
4140 DUE TO, OR AS A CONSEQUENCE OF							11 days
(b) Left Cerebral Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Arterio Sclerotic Heart disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
Dementia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/30/80 19, to 7/21/80 19, that (I) (we) lost the deceased alive on 7/21/80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Jeremy Cooke				7/21/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
Jeremy Cooke MD		10400 Conn Ave Kensington MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		7/26/80		BURLINGAME		BURLINGAME-OSAGE-KANSAS	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO.		JUL 28 1980		Jury M. M. M.			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 8 7 0 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Barbara		Strong		7		13 80		2 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		WHITE		OCT 17, 1938		41		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
OHIO		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban HOSPITAL		EXECUTIVE SECRE. U.S. GOVT					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4609 EADES STREET	
14. FATHER'S NAME		MIDDLE LAST		15. MOTHER'S MAIDEN NAME		MIDDLE LAST			
ROBERT		LIMPUS		CATHERINE		SAWYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		363-38-0644		BRUCE D. STRONG		SAME AS 13		HUSBAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		b)		c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1749		DUE TO, OR AS A CONSEQUENCE OF		carcinomatosis		carcinoma of the breast		6 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from		19 7/25		19 7/8		to 7/13		19 80, that (I) (we) last saw the deceased alive on	
above (I) (we) (did not) view the body after death.		19 80							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
John J. Lynch		MD		7/14/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JOHN J. LYNCH		106 IRVING ST NW WASH DC 20010							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL		7/17/80		GATE OF HEAVEN		SILVER SPRING		MONT MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS		JUL 17 1980		Bobby McCreedy					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 18710

1. FOR REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST CHARLES WADE STUBY SR.		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX male		4. RACE white		5. DATE OF BIRTH April 3, 1909	
6. AGE IN YEARS (LAST BIRTHDAY) 21 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH St. Louis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2714 Lindell St		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter	
13a. STATE Md		13b. CITY OR TOWN St. Louis		13c. STREET ADDRESS 2714 Lindell St	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Stuby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melissa - Miller		16. SOCIAL SECURITY NO. 216-07-2752-A	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		17. INFORMANT ADDRESS Agnes C. Stuby Same as # 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Acute Myocardial Dis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) Chronic Myocardial Dis.			
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Rogers M.D.		TITLE (SPECIFY) Dep.		MEDICAL EXAMINER DATE SIGNATURE July 31, 1980	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Laytonsville	
23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.		23e. DATE RECEIVED BY REGISTRAR Aug 5 1980		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760					

018 12/18/55

Dear Mr. [illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
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12/18/55

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

REG. NO.

1 8 7 1 1

1. DECEASED NAME (TYPE OR PRINT) <b>Anna S Stump</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>20</b> YEAR <b>80</b>		2b. HOUR <b>11:55 A.M.</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH <b>Sept</b> DAY <b>25</b> YEAR <b>1923</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		# UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD		
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian - Lib. of Congress</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Charles</b> 13c. CITY OR TOWN <b>Bryans Road</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-40-9739</b>		17 INFORMANT <b>William E. Stump, Husband,</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bowel Obstruction</b> 1590 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Leiomyosarcoma Bowel</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Extensive Metastatic Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 wks.</b> <b>4 mo</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>7-2-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal abscess</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> 19 <b>80</b> to <b>Present</b> 19 <b></b> , that (I) (we) last saw the deceased alive on <b>6-19</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert A. Smith</b>		22c. DATE SIGNED <b>7-20-80</b>		22d. ADDRESS <b>831 University Blvd &amp; Sil Spr Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-23-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
24 FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>		24b. ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>Debra K. Crosby</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

1131

8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(FORM 15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18712

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Gregory P. Swaim		MONTH DAY YEAR 7 12 1980		M 4:40 P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	MONTH DAY YEAR Nov. 15 1940	39 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	U.S.A.			Montgomery County MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Brookville	21005 Blk. Georgia Avenue	Foreman		Telephone Co.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Carroll	Sykesville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6311 Old Washington Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Russell Swaim		FIRST MIDDLE LAST Elva Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		1960		218 38 5254 Lucy Swaim Sykesville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple Traumatic Injuries					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:30 A.M. 7 12 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION CITY OR TOWN COUNTY STATE 21005 Blk. Georgia Ave., Silver Spring, Montgomery Co., Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Thomas D. Smith		M.D. Deputy Chief		7-13-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Thomas D. Smith, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-16-80		Crestlawn Cemetery	
24. FUNERAL DIRECTOR NAME		ADDRESS		23d. LOCATION CITY OR TOWN COUNTY STATE	
Harry W. Haight		Sykesville, Md.		Marriottsville, Howard Md.	
		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		JUL 21 1980			

